



# Medicaid Provider Billing Workshop

## Presenters:

Jason Bergman, Provider Relations Unit

Marci Thietje, Provider Relations Unit

Matt Ashton, Provider Relations Unit

Bill Camerer, Provider Relations Unit

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# Who is Provider Relations and what do we do?

Provide outreach and training for Washington Apple Health (Medicaid) providers

Specialize in the use of the ProviderOne portal

Assist with program and policy questions

Medicaid  
Overview

ProviderOne

Topics

Billing  
Processes

Resources

# Medicaid Overview

# Medicaid Overview

Medicaid is no longer managed by DSHS

Medicaid is managed by the Health Care Authority

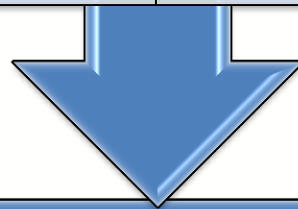
“Apple Health” is the new name for Medicaid

# Medicaid Overview

How Medicaid purchases care

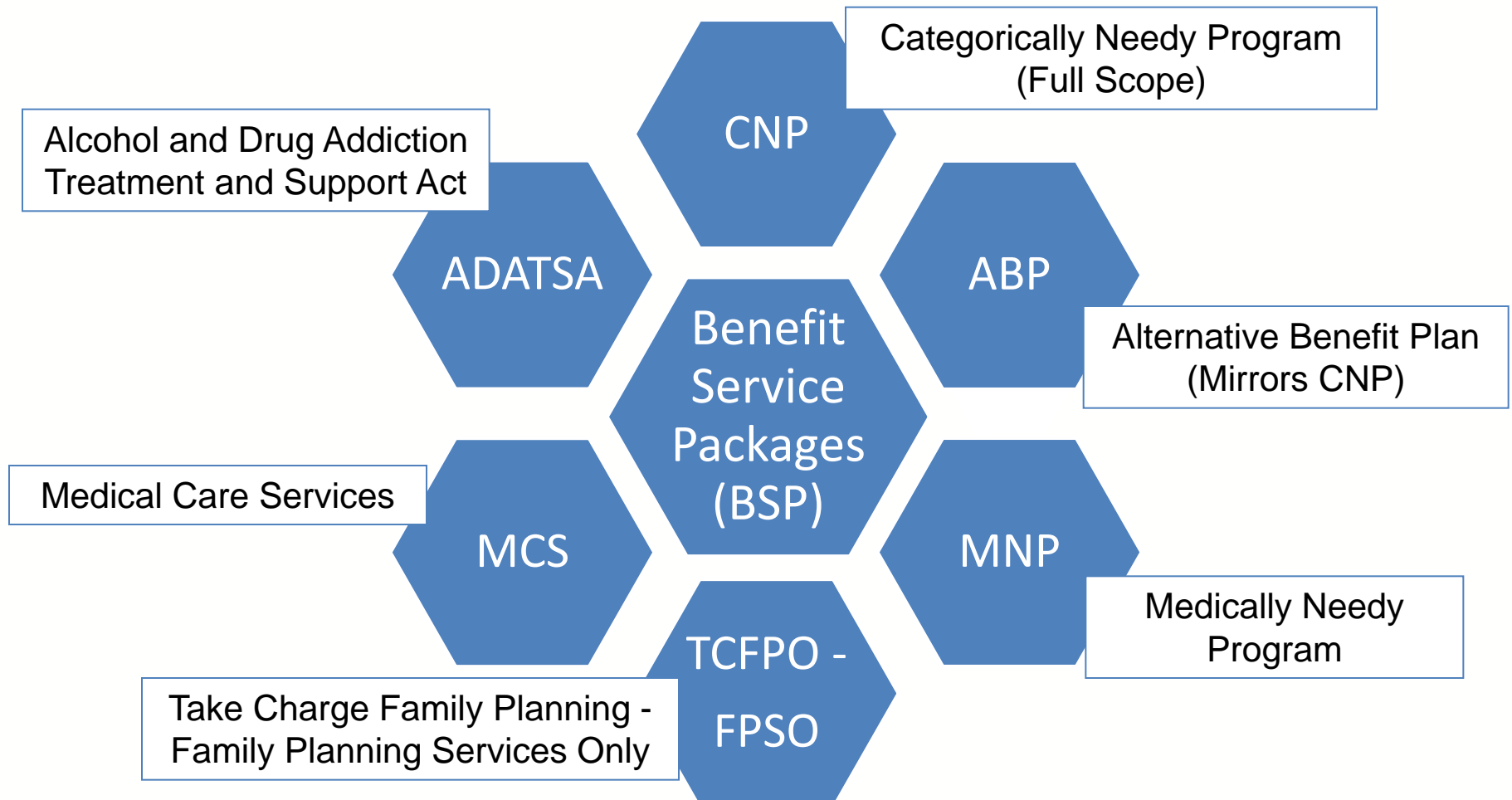
Fee for Service program

Managed Care



HCA's goal is to have the majority of Medicaid clients on Managed Care. "Migration" to the plans started July 2012.

# Eligibility Programs



For complete listing of BSP, visit:

[http://www.hca.wa.gov/medicaid/provider/Documents/provideroneguide/appendix\\_e.pdf](http://www.hca.wa.gov/medicaid/provider/Documents/provideroneguide/appendix_e.pdf)

# ProviderOne

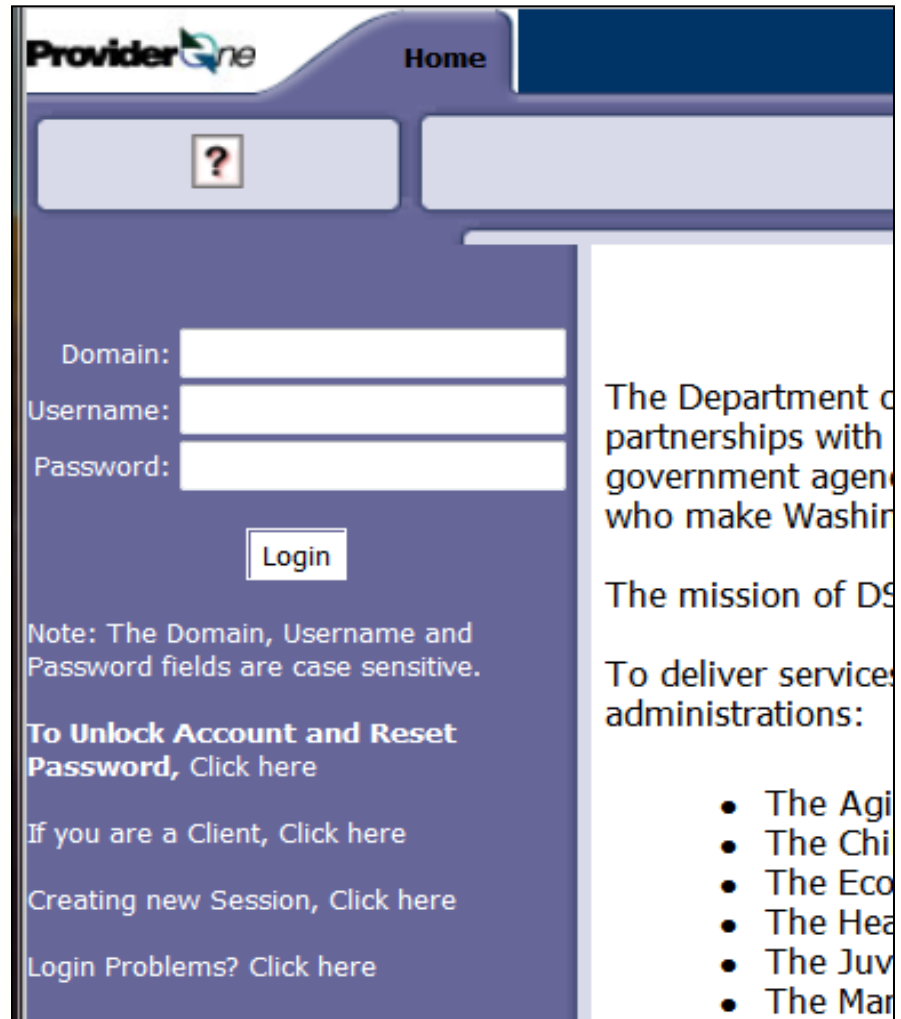


# Accessing ProviderOne

- Before logging into ProviderOne:
  - ✓ Make sure you are using Microsoft Internet Explorer version 6.0 and above
  - ✓ Turn **OFF** the Pop Up Blocker
  - ✓ Make sure you are using a PC (MACs are not supported by ProviderOne)

# Accessing ProviderOne

- ✓ Use web address  
<https://www.waproviderone.org>
- ✓ Ensure that your system **"Pop Up Blocker"** is turned **"OFF"**
- ✓ Login using assigned Domain, Username, and Password
- ✓ Click on the **"Login"** button



The screenshot shows the ProviderOne login interface. At the top, there is a navigation bar with the "ProviderOne" logo and a "Home" link. Below the navigation bar, there is a search bar with a question mark icon. The main content area is divided into two columns. The left column contains the login form with fields for "Domain:", "Username:", and "Password:", followed by a "Login" button. Below the login form, there is a note: "Note: The Domain, Username and Password fields are case sensitive." and a link: "To Unlock Account and Reset Password, Click here". At the bottom of the left column, there are two more links: "If you are a Client, Click here" and "Creating new Session, Click here". The right column contains text about the Department of Social & Health Services (DSHS) and its mission, followed by a list of links: "The Ag...", "The Chi...", "The Eco...", "The Hea...", "The Juv...", and "The Mar...".

# ProviderOne Users

## **HCA establishes System Administrators for your domain/NPI**

- A System Administrator can assign profiles to other users as necessary
- Staff can be assigned one or more security profiles to meet their job duties and provide them the level of access necessary in the system.

ProviderOne Security web page link:

<http://www.hca.wa.gov/medicaid/providerone/pages/phase1/security.aspx>


# How to Get Access in ProviderOne

- Review the ProviderOne Security Manual at <http://www.hca.wa.gov/medicaid/providerone/pages/phase1/security.aspx>
- New provider and don't have the form? Email ProviderOne Security at: [provideronesecurity@hca.wa.gov](mailto:provideronesecurity@hca.wa.gov) (in the subject line enter "Request for ProviderOne User Access Request form")

# How to Get Access in ProviderOne

- The ProviderOne User Access Request form is for a newly enrolled Facility, Clinic, Individual Provider, or a new Office Administrator.
- Complete the form and fax to: 360-507-9019.

State of Washington

 **ProviderOne User Access Request**

**IMMEDIATE ACTION REQUIRED**

ProviderOne Id:

*In order to gain access to ProviderOne, you must complete and return this form. This form will be used to establish the System Administrator for your assigned Domain (ProviderOne ID) in the ProviderOne system.*

*The System Administrator is responsible for maintaining access to ProviderOne for your staff; which includes setting up accounts for additional users, assigning profiles to user accounts, and resetting user passwords.*

*Once you have completed and returned this form, we will send a username and a temporary password in two separate emails to the email address you provide.*

ProviderOne System Administrator Information	
Name of System Administrator (First, Middle Initial, Last) <input type="text"/>	Physical Address Street: <input type="text"/> City: <input type="text"/> , State: <input type="text"/> Zip: <input type="text"/>
System Administrator's Date of Birth mm/dd/yyyy <input type="text"/>	Business Name <input type="text"/>
System Administrator's Individual Email Address (generic email addresses will not be accepted) <input type="text"/>	National Provider Identifier (NPI if applicable) <input type="text"/>
System Administrator's Phone Number <input type="text"/>	Federal Tax ID (FEIN/SSN) <input type="text"/>

**Each domain user must have his/her own account:**

With the system administrator login information, we will send instructions on how to create additional user accounts for your Domain and how to add profiles to the accounts.

To better understand the different types of user profiles, look for the **Provider Information** link on our site: <http://www.hca.wa.gov/Medicaid/provider/Pages/index.aspx>

**To review or update provider information:**

You may edit information in your provider file at anytime by using the EXT Provider Maintenance or EXT Super User profile. Once you receive your login information, please verify the accuracy of all the data in your providerfile.

- Address Information
- Payment Detail; and
- Electronic Data Interchange Information if you plan on submitting HIPAA batch files

If updates are made in the Provider File Business Process Wizard, please make sure you go to the last step and **submit** your modification request for review and approval. Include a copy of the bar code coversheet on any documentation you send. [http://hrsa.dshs.wa.gov/download/document\\_submission\\_cover\\_sheets.html](http://hrsa.dshs.wa.gov/download/document_submission_cover_sheets.html)

**Return this completed form by email: [provideronesecurity@hca.wa.gov](mailto:provideronesecurity@hca.wa.gov), or**  
**Fax to: (360) 507-9019 or**  
**Mail to: HCA IT Security, PO Box 45512, Olympia, WA 98504-5512**

# How to Set Up a User

- Log in with the **System Administrator** Profile
- Click on **Maintain Users**
- The system now displays the User List screen
- Click on the **Add** button

<b>Provider</b>	Hide/Max
<a href="#">Provider Inquiry</a>	
<a href="#">Manage Provider Information</a>	
<a href="#">Initiate New Enrollment</a>	
<a href="#">Track Application</a>	
<b>HIPAA</b>	Hide/Max
<a href="#">Submit HIPAA Batch Transaction</a>	
<a href="#">Retrieve HIPAA Batch Responses</a>	
<b>Admin</b>	Hide/Max
<a href="#">Change Password</a>	
<a href="#">Maintain Users</a>	

Welcome Administrator, System . You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal / UserList  
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Menu

Close **Add** Approve Reject

Manage Users:

Filter By :  And  With Status: Approved

<input type="checkbox"/>	Name	Domain Name	Organization	Status	Start Date	End Date
<input type="checkbox"/>	Administrator, System	2857403	Mario Health Center	Approved	09/01/2009	12/31/2009

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS


# How to Set Up a User

## ➤ Adding a user

Add User:

Please enter the following information:

First Name: <input type="text"/> *	Middle Name: <input type="text"/>
Last Name: <input type="text"/> *	
User Login ID: <input type="text"/> *	User Type: Batch User *
Date of Birth: <input type="text"/> *	EID: <input type="text"/> *
Domain Name: 9999999	
Start Date: 02/19/2014 *	Expiration Date: 12/31/2999 *
Status: In Review	
Comments: <input type="text"/>	




Next Cancel

Add User:

Please enter the following information:

User Login ID: smithg	Domain: 9999999
Password: <input type="text"/> *	Confirm Password: <input type="text"/> *
Email: <input type="text"/> *	
Phone Number: <input type="text"/> *	Pager Number: <input type="text"/>
Mobile Number: <input type="text"/>	
Address Line 1: <input type="text"/>	Address Line 2: <input type="text"/>
(Enter Street Address or PO Box Only)	
Address Line 3: <input type="text"/>	City/Town: <input type="text"/>
State/Province: <input type="text"/>	County: <input type="text"/>
Country: <input type="text"/>	Zip Code: <input type="text"/> - <input type="text"/> Address



Back Finish Cancel

➤ Fill in all required boxes that have an asterisk \*

➤ The address is not needed here

# How to Set Up a User

- To Display the new user
  - ✓ In the **With Status** box display **In Review**, then click **Go**
  - ✓ The user's name is displayed with In Review status.
  - ✓ Click the box left of the user's name, then click the **Approve** button to approve this user.

Welcome Administrator, System . You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal / UserList  
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Menu

Close Add Approve Reject

Manage Users:

Filter By : [ ] And [ ] With Status: All [Go]

	Name	Domain Name	Organization	Status	Start Date	End Date
<input type="checkbox"/>	Administrator, System	2857403	Mario Health Center	Approved	09/01/2009	12/31/2999
<input type="checkbox"/>	Kim, Linda	2857403	Mario Health Center	In Review	09/10/2009	12/31/2999

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS



# How to Set Up a User

## ➤ Adding Profiles

- ✓ Get here by clicking on the users name on the previous screen.

Welcome Administrator, System : You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal/ UserList/ UserDetails  
User Login Id : KimL Name: Kim, Linda

Menu

Close Save

User Details:

First Name: Linda Middle Name: Lock User: ☐

Last Name: Kim Date of Birth: 08/13/1975 Domain Name: 2857403

EID: 02376 User Type: NON-PHYSICIAN STAFF

User Name: Linda Password: Confirm Password:

Address Line 1: City/Town: County: Zip Code: - Address

Address Line 3: State/Province: Expiration Date: 12/31/2999

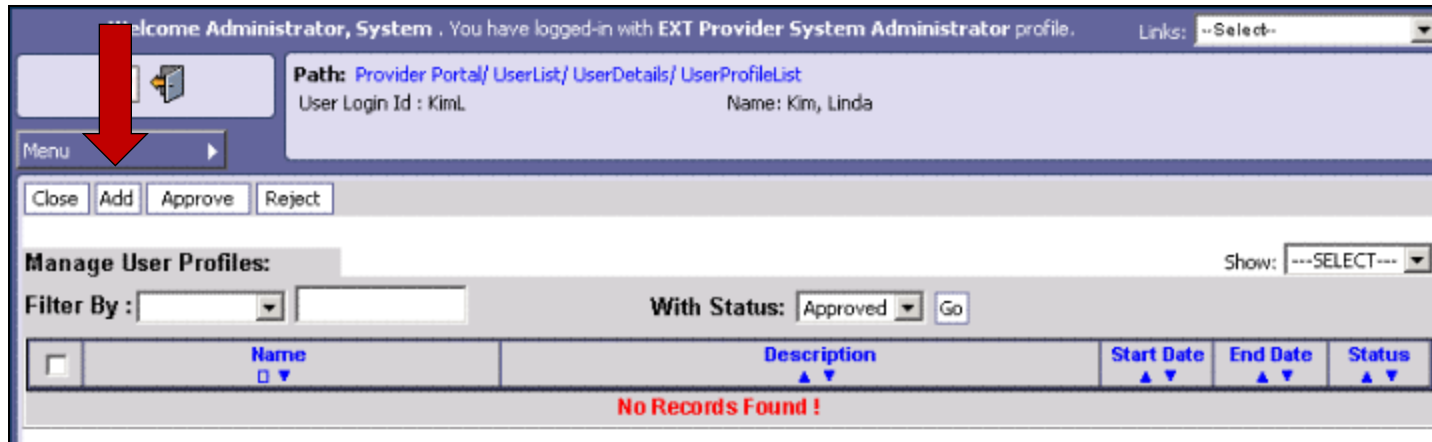
Show: ---SELECT---  
---SELECT---  
Associated Profiles  
Check List

- ✓ On the Show menu click on **Associated Profiles**.

# How to Set Up a User

## ➤ Adding Profiles

- ✓ Click on the **Add** button to select profiles



Welcome Administrator, System . You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal/ UserList/ UserDetails/ UserProfileList  
User Login Id : KimL Name: Kim, Linda

Menu

Close Add Approve Reject

Manage User Profiles: Show: ---SELECT---

Filter By : [ ] With Status: Approved [Go]

	Name □ ▼	Description ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼	Status ▲ ▼
No Records Found !					

# How to Set Up a User

## ➤ Adding Profiles

The screenshot shows a web browser window titled "Add New Profiles to User - Windows Internet Explorer". The page has a header with a question mark icon and the title "Add New Profiles to User:". Below this, the "User Name: Kim, Linda" is displayed. There are two date fields: "Start Date: \* 09/10/2009" and "End Date: \* 12/31/2999". The main content area is divided into two sections: "Available Profiles" on the left and "Associated Profiles" on the right. The "Available Profiles" list includes: EXT Provider Claims Payment Status Checker, EXT Provider Claims Submitter, EXT Provider Download Files, EXT Provider Eligibility Checker, EXT Provider Eligibility Checker-Claims Submitter, EXT Provider File Maintenance, EXT Provider File View Only, EXT Provider Managed Care Only, EXT Provider Upload Files, and EXT Provider Upload and Download Files. The "Associated Profiles" list includes: EXT Provider Super User and EXT Provider System Administrator. Between the two lists are two buttons: ">>" and "<<". A red arrow points from the "Available Profiles" list to the ">>" button. At the bottom right of the window, there are "OK" and "Cancel" buttons, with a red arrow pointing to the "OK" button.

## ➤ Highlight Available Profiles desired

- ✓ Click **double arrow** and move to Associated Profiles box then click the **OK** button.

# How to Set Up a User

## ➤ Adding Profiles

Welcome Administrator, System . You have logged-in with EXT Provider System Administrator profile. Links: --Select--

Path: Provider Portal/ UserList/ UserDetails/ UserProfileList  
User Login Id : KimL, Name: Kim, Linda

Menu

Close Add **Approve** Reject

Manage User Profiles: Show: --SELECT--

Filter By : [ ] [ ] **With Status:** All [Go]

	Name	Description	Start Date	End Date	Status
<input type="checkbox"/>	EXT Provider System Administrator	EXT Provider System Administrator	09/10/2009	12/31/2999	In Review
<input type="checkbox"/>	EXT Provider Super User	EXT Provider Super User	09/10/2009	12/31/2999	In Review

<< Prev Viewing Page 1 Next >> 1 Go Page Count Save To XLS

## ➤ To Display the new profiles

- ✓ In the **With Status** box display **All**, then click **Go**.
- ✓ The profiles are displayed with In Review status.
- ✓ Click the box left of the profile name, then click the **Approve** button. Profiles will then be approved.

# How to Set Up a User

## ➤ How to set up a user's password

The screenshot shows a web-based form for setting up a user. At the top left are 'Close' and 'Save' buttons. Below them is the 'User Details:' section. The form contains several input fields: First Name (Linda), Middle Name (empty), Last Name (Kim), Date of Birth (08/13/1975), EID (02376), User Name (Linda), Password (empty), Confirm Password (empty), Address Line 1 (empty), Address Line 3 (empty), State/Province (empty), Country (empty), Start Date (09/10/2009), Domain Name (2857403), User Type (NON-PHYSICIAN STAFF), City/Town (empty), County (empty), Zip Code (empty), and Expiration Date (12/31/2999). A 'Show: ---SELECT---' dropdown is at the top right. At the bottom left, the status is 'Approved'. Two large red arrows point to the 'Password' and 'Confirm Password' fields, indicating where to enter the password.

Close Save

User Details: Show: ---SELECT---

First Name: Linda Middle Name:

Last Name: Kim Lock User: ☐

Date of Birth: 08/13/1975 Domain Name: 2857403

EID: 02376 UserType: NON-PHYSICIAN STAFF

User Name: Linda

Password: Confirm Password:

Address Line 1: City/Town:

(Enter Street Address or PO Box Only)

Address Line 3: County:

State/Province: Zip Code: - Address

Country: Expiration Date: 12/31/2999

Start Date: 09/10/2009

Status: Approved

# How to Manage a User

- How to reset a password
  - Enter the new temporary password and click **Save**

The screenshot shows a 'User Details' form with the following fields and values:

- Close** **Save**
- User Details:** [Search Bar] **Show:** ---SELECT---
- First Name:** Linda
- Last Name:** Kim
- Date of Birth:** 08/13/1975
- EID:** 02376
- User Name:** Linda
- Password:** [Empty] (Red arrow points here)
- Address Line 1:** [Empty] (Enter Street Address or PO Box Only)
- Address Line 3:** [Empty]
- State/Province:** [Empty]
- Country:** [Empty]
- Start Date:** 09/10/2009
- Status:** Approved
- Middle Name:** [Empty]
- Lock User:** ☐ (Red arrow points here)
- Domain Name:** 2857403
- UserType:** NON-PHYSICIAN STAFF
- Confirm Password:** [Empty] (Red arrow points here)
- City/Town:** [Empty]
- County:** [Empty]
- Zip Code:** [Empty] - [Empty] **Address**
- Expiration Date:** 12/31/2999

✓ To lock or unlock a User, click this box!

# How to Manage a User

## ➤ How to end a user in ProviderOne

The screenshot shows the 'User Details' form in the ProviderOne system. At the top left, there are 'Close' and 'Save' buttons. A red arrow points to the 'Save' button. The form contains various fields for user information: First Name (Linda), Middle Name, Last Name (Kim), Date of Birth (08/13/1975), EID (02376), User Name (Linda), Password, Confirm Password, Address Line 1, Address Line 3, State/Province, Country, Start Date (09/10/2009), Status (Approved), Lock User (checkbox), Domain Name (2857403), UserType (NON-PHYSICIAN STAFF), City/Town, County, Zip Code, and Expiration Date (12/31/2999). A red arrow points to the 'Expiration Date' field. A 'Show: ---SELECT---' dropdown is located at the top right. A small 'Address' button is next to the Zip Code field.

- ✓ Enter the end date and click the **save** button.
- ✓ The account will be removed from view after the system refreshes overnight.

# How can we help?

## Provider Enrollment

- Assists with enrollment of billing/servicing providers
- Can be contacted at 800-562-3022, ext. 16137

## User profiles

- Provider Relations can assist in a variety of formats tailored to individual needs
- To request assistance, send email to [providerrelations@hca.wa.gov](mailto:providerrelations@hca.wa.gov)



# Eligibility

# How Do I Obtain Eligibility In ProviderOne

- Select the proper user profile

1

Welcome  
to the  
Medicaid Management Information System  
for

Washington State  
DSHS

Select a profile to

**Note:** There are three different profiles that can be used for checking client eligibility in ProviderOne

- EXT Provider Eligibility Checker
- EXT Provider Eligibility Checker-Claims Submitter
- EXT Provider Super User

2

Online Services:

Claims [Hide/Max](#)

- [Claim Inquiry](#)
- [Claim Adjustment/Void](#)
- [On-line Claims Entry](#)
- [On-line Batch Claims Submission \(837\)](#)
- [Resubmit Denied/Voided Claim](#)
- [Retrieve Saved Claims](#)
- [Manage Templates](#)
- [Create Claims from Saved Templates](#)
- [Manage Batch Claim Submission](#)

Client [Hide/Max](#)

- [Client Limit Inquiry](#)
- [Benefit Inquiry](#)

Select "Benefit Inquiry" under the "Client" section of the Provider Portal

# How Do I Obtain Eligibility In ProviderOne

➤ Use one of the search criteria listed along with the dates of service to verify eligibility.

Close Submit

To submit an Eligibility Inquiry on a specific client, complete one of the following criteria sets and click 'Submit'.

- ProviderOne Client ID(Client Identification Code) or
- Last Name, First Name AND Date of Birth or
- Last Name, First Name AND SSN or
- SSN AND Date of Birth
- ProviderOne Client ID(Client Identification Code), Last Name, First Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code), Last Name AND Date of Birth or
- ProviderOne Client ID(Client Identification Code) AND Last Name

Please contact Customer Service Center at (800) 562-3022

Client Eligibility Inquiry:

ProviderOne Client ID:  SSN:

Last Name:  First Name:

Date of Birth:

Inquiry Start Date: 12/20/2011 \* Inquiry End Date: 12/20/2011 \*

➤ An unsuccessful check would look like this:

Printer Friendly Version

Close Submit Another Inquiry Exit

Selection Criteria Entered:

Date of Request: 12/20/2011  
Time in Request: 09:02:28 AM PST  
Provider ID: 200320900  
From Date of Service: 12/20/2011  
To Date of Service: 12/20/2011

Search Criteria Used

ProviderOne Client ID:  
Client Date of Birth: 05/16/1973  
Client SSN:  
Client Last Name: JONES  
Client First Name: JOE

Client Demographic Information:

ProviderOne Client ID:  
Client First,Middle,Last Name:  
CSO/HCS:  
County Code:  
CSOR:  
Date of Birth:  
Gender:  
Language:  
Placement:  
ACES Client ID:  
HIC:

System Response Information:

Valid Request Indicator: N  
Reject Reason Code: 75 - Subscriber/Insured ID Not Found  
Follow-Up Action Code: C - Please correct data and resubmit

Unsuccessful eligibility checks will be Returned with an error message here.

✓ Client is not eligible for your search dates; or

✓ Check your keying!

# Successful Eligibility Check

Printer Friendly Version

Selection Criteria Entered:

**4**

Date of Request: 12/20/2011  
Time in Request: 10:11:16 AM PST  
Provider ID: 110320900  
From Date of Service: 12/20/2011  
To Date of Service: 12/20/2011

**Search Criteria Used**

ProviderOne Client ID: 600212788WA  
Client Date of Birth:  
Client SSN:  
Client Last Name:  
Client First Name:

---

Client Demographic Information:

ProviderOne Client ID: 600212788WA  
Client First,Middle,Last Name:  
CSO/HCS: 133-OAK HARBOR/ISLAND COUNTY HCS  
County Code: 015-Island  
CSOR: 015-OAK HARBOR CSO  
Date of Birth: 06/28/1951  
Gender: Female  
Language: ENG-English  
Placement:  
ACES Client ID: 602411160  
HIC:

System Response Information:

Valid Request Indicator:  
Reject Reason Code:  
Follow-Up Action Code:

**Basic client information returned including the Client ID, Gender, and Date of Birth**

**Note:** The eligibility information can be printed out using the “**Printer Friendly Version**” link located in the upper left corner.

# Successful Eligibility Checks

➤ After scrolling down the page the first entry is the “**Client Eligibility Spans**” which shows:

- ✓ The eligibility program (CNP, MNP, etc).
- ✓ The date span for coverage.

Insurance Type Code	Recipient Aid Category (RAC)	Benefit Service Package	Eligibility Start Date	Eligibility End Date	ACES Coverage Group	ACES Case Number	Retro Eligibility	Delayed Certification
MC: Medicaid	1147	CNP	02/01/2011	12/31/2999	L21			

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | Save To XLS

**Note:** Clicking on the “**CNP**” hyperlink will display the “Benefit Service Package” which is a list of covered services for the client.

## “Managed Care Information”

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	MHC Healthy Options	105010201	(800) 869-7165		06/01/2010	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	Spokane County Regional Support Network	105021301	(800) 273-5564		06/01/2010	12/31/2999

<< Prev | Viewing Page 1 | Next >> | 1 | Go | Page Count | Save To XLS

Healthy Options Managed Care plans will be listed

The local Regional Support Network for Medicaid client's mental health services will be displayed in this section.

PCP clinic name populated here when available for RHC's, FQHC's, and PCCM's.

# Successful Eligibility Checks

## “Medicare Eligibility Information”

Medicare Eligibility Information			
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼
30: Health Benefit Plan Coverage	MB: Medicare Part B	03/01/1980	12/31/2999
30: Health Benefit Plan Coverage	MA: Medicare Part A	02/01/1979	12/31/2999
<< Prev   Viewing Page 1   Next >>   1   Go   Page Count   SaveToXLS			

- If client has Medicare Part A or Part B this information will be shown with the Medicare eligibility effective dates of service.
- If the client has enrolled in a Medicare Advantage Plan (Part C), if reported, it is listed in the **“Coordination of Benefits Information”** section.

Coordination of Benefits Information									
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Insurance Co. Name & Contact ▲ ▼	Carrier Code ▲ ▼	Policy Holder Name ▲ ▼	Policy Number ▲ ▼	Group Number ▲ ▼	Plan Sponsor ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/2011
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/2010
<< Prev   Viewing Page 1   Next >>   1   Go   Page Count   SaveToXLS									

# Successful Eligibility Checks

## “Coordination of Benefits Information”

- Will display phone number and any policy or group numbers on file with WA Medicaid for the commercial plans listed.
- For DDE claims the Carrier Code (Ins. ID) is found here.

Coordination of Benefits Information									
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Insurance Co. Name & Contact ▲ ▼	Carrier Code ▲ ▼	Policy Holder Name ▲ ▼	Policy Number ▲ ▼	Group Number ▲ ▼	Plan Sponsor ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
30: Health Benefit Plan Coverage	C1: Commercial	KAISER PERMANENTE MED CARE (800) 813-2000	HM10		13482256			09/01/2010	12/31/2999
<div>&lt;&lt; Prev   Viewing Page 1   Next &gt;&gt;   1   Go   Page Count   Save To XLS</div>									

- There are two ways to update any COB information in ProviderOne:
  - Provider or client can contact COB 1-800-562-3022 extension 16134
  - Submit claim with EOB information which can be used to update ProviderOne.

# Successful Eligibility Checks

## “Restricted Client Information”

- Client's may be restricted to specific Hospitals, PCP's, and Pharmacies for care. A referral is required from the PCP for specialized care.

Restricted Client Information				
Assignment Type ▲ ▼	Provider Name ▲ ▼	Provider Phone Number ▲ ▼	Period Start Date ▲ ▼	Period End Date ▲ ▼
Hospital	MULTICARE HEALTH SYSTEM		01/05/2010	12/31/2999
Pharmacy	WALGREEN CO		01/01/2010	12/31/2999
Primary Care Physician	SEA-MAR COMMUNITY HEALTH CENTER		01/01/2010	12/31/2999
Primary Care Physician	DITTMER, STEPHANIE		01/01/2010	12/31/2999

<<Prev Viewing Page 1 Next>> 1 Go Page Count SaveToXLS



# Successful Eligibility Checks

## "Hospice Information"

- Client's may be enrolled in a Hospice agency for care:

Hospice agency ▲ ▼	Hospice Address ▲ ▼	Hospice Phone ▲ ▼	Hospice Contact ▲ ▼	Start date ▲ ▼	End date ▲ ▼
102071700	PROVIDENCE HOSPICE OF SEAT, 425 PONTIUS AVE N STE 300, SEATTLE, WA 98109-5312			03/15/2011	03/18/2011

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**Note:** If a client is assigned to a Hospice agency, bill the Hospice agency for any care related to the client's terminal illness. WA Medicaid has paid a monthly payment to the agency to cover these services.

**Note:** If service is not related to the client's terminal illness, bill these services to WA Medicaid with a note "SCI=K" or with a statement "Not related to terminal illness".

- The last section of the eligibility check lists the source of the eligibility data.

# Successful Eligibility Checks

## "Foster Care Information"

- Foster Care Client's Medical Records History is available.
  - ✓ There is an extra button at the top of the eligibility screen.

Printer Friendly Version

Close Submit Another Inquiry **Medical Records** Exit

Selection Criteria Entered:

Date of Request: 08/18/2011	ProviderOne Client ID: 564532100WA
Time in Request: 07:20:08 AM PDT	Client Date of Birth:
Provider ID:	Client SSN:
From Date of Service: 08/18/2011	Client Last Name:
To Date of Service: 08/18/2011	Client First Name:

---

<b>Client Demographic Information:</b>	<b>System Response Information:</b>
ProviderOne Client ID: 564532100WA	Valid Request Indicator:
Client First,Middle,Last Name: UNCLE SAM	Reject Reason Code:
CSO/HCS: 076-MEDS	Follow-Up Action Code:
County Code: 017-King	
CSOR: 043-KING SOUTH CSO	
Date of Birth: 12/28/2003	
Gender: Male	

- ✓ Click the button to see:
  - Pharmacy services claims.
  - Medical services claims (includes dental).
  - Hospital services claims.
- See the [Billing and Resource Guide](#) for complete details. Web address is on the last slide.

# Successful Eligibility Checks

## "Foster Care Information"

➤ Foster Care Client's Medical Records History shows claims paid by ProviderOne. Each section looks like:

- ✓ If any field is empty there is no data for it.
- ✓ Sort by using the "diamonds" under each column name:
- ✓ Search by using the "Filter by Period" boxes.
- ✓ If there is more pages of data use the "Next" or "Previous" buttons:

<< Prev Viewing Page 1 Next >>

- ✓ If there is no data for the section it will display:

**No Records Found !**

Printer Friendly Version

Close

Pharmacy:

Filter By Period: All

Fill Date	Drug Name	Strength	Qty	Days	Refill Sequence	Prescriber Name	Pharmacy Name	Pharmacy Phone #
02/03/2011	VITAMIN D	1000 UNIT	60	30	00	FRANKLIN,BEH	BIG RIVER PHARMACY	(509) 555-2323
01/27/2011	POLYETHYLENE GLYCOL 3350	0	527	30	01	FRANKLIN,BEH	BIG RIVER PHARMACY	(509) 555-2323
01/18/2011	BACLOFEN	20 MG	90	30	00	FRANKLIN,BEH	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	LAN SOPRAZOLE ODT	15 MG	60	30	00	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323
01/12/2011	IBUPROFEN	400 MG	15	10	01	WASHINGTON,GEORGE	BIG RIVER PHARMACY	(509) 555-2323

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

Medical Services (primary and specialty care):

Filter By Period: All

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	Procedure Code	Servicing Provider Name	Billing Provider Name	Billing Provider Phone #
02/02/2011	02/02/2011			D1120,D1203,D0150,T1015	HAMILTON, ANDREW	BIG RIVER DENTAL CLINIC	(509) 555-5678
01/24/2011	01/24/2011	3439 - Cerebral palsy NOS	7689,5181	A0425,A0428		MEDICAL AMBULANCE SERVICE	(509) 555-2222
01/24/2011	01/24/2011	78097 - Altered mental status	3481,79091,51881	A0425,A0429		MEDICAL AMBULANCE SERVICE	(206) 535-4444
12/16/2010	01/15/2011	V440 - Tracheostomy status	85400,04112,51889	E0445		HOME NURSING SUPPLY	(509) 555-3333
01/04/2011	01/04/2011	V440 - Tracheostomy status	81889,85400,04112	A7525		HOME NURSING SUPPLY	(509) 555-3333

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

Hospital Care:

Filter By Period: All

Start Date	End Date	Primary Code/DX Description	Other Diagnosis Codes	ER/Outpatient/Inpatient	DRG Description	Attending Provider Name	Billing Provider Name	Billing Provider Phone #
01/24/2011	01/24/2011	47874 - Stenosis of larynx	3481,V440,37775,53081	Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167
01/11/2011	01/11/2011	51919 - Trachea & bronchitis NEC		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
10/27/2010	10/27/2010	85406 - Brain inj NEC-coma NOS		Outpatient		KIDD, CISCO	MEMORIAL HOSPITAL	(509) 555-6789
09/30/2010	09/30/2010	78720 - Dysphagia NOS	78722	Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167
09/21/2010	09/21/2010	47874 - Stenosis of larynx		Outpatient		EAGLECLAW, DAN	CHILDRENS	(206) 535-2167

<< Prev Viewing Page 1 Next >> 2 Go Page Count SaveToXLS

# Direct Data Entry Claims (DDE)

# After this training, you can:

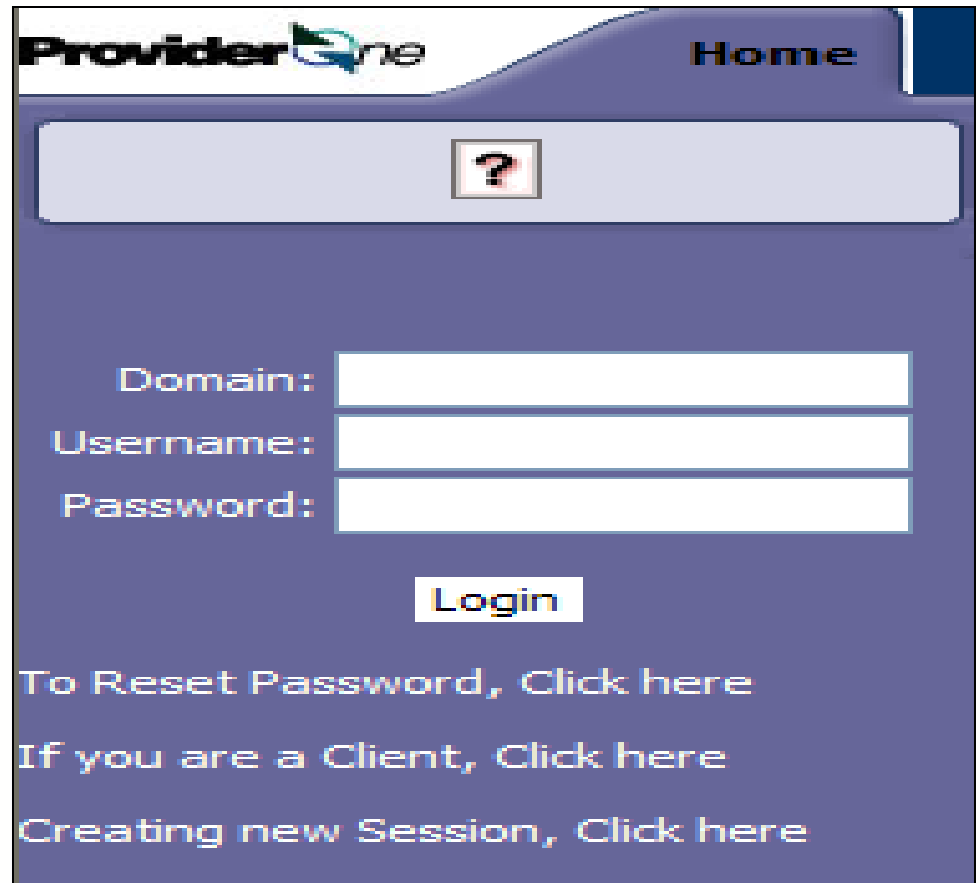
- Submit FFS direct data entry (DDE) claims
- Create and Submit TPL secondary DDE claims
  - ✓ With backup
  - ✓ Without backup
- Submit TPL secondary claims electronically
  - ✓ Without BU
- Bill Medicare crossovers (XO) and commercial private insurance (TPL) on same claim
- No information about pharmacy claims is discussed in this training

# Direct Data Entry Claims (DDE)

- ProviderOne allows providers to enter claims directly into the payment system
- All claim types can be submitted through the DDE system
  - ✓ Professional (CMS 1500)
  - ✓ Institutional (UB-04)
  - ✓ Dental (ADA Form)
- Providers can correct and resubmit denied or previously voided claims
- Providers can ADJUST or VOID previously paid claims

# Accessing ProviderOne


- Use web address  
<https://www.waproviderone.org>
- Ensure that your system **"Pop Up Blocker"** is turned **"OFF"**
- Login using assigned Domain, Username, and Password
- Click on the **"Login"** button



The screenshot shows the ProviderOne login interface. At the top, there is a header with the "ProviderOne" logo on the left and a "Home" link on the right. Below the header is a light blue banner containing a question mark icon. The main login area has a dark blue background. It features three white input fields labeled "Domain:", "Username:", and "Password:". Below these fields is a white "Login" button. At the bottom of the page, there are three links: "To Reset Password, Click here", "If you are a Client, Click here", and "Creating new Session, Click here".

# Determine what profile to use

Welcome  
to the  
Medicaid Management Information System  
for



Select a profile to use during this session:

EXT Provider Super User	▼	* Go
EXT Provider Claims Submitter		
EXT Provider Eligibility Checker-Claims Submitter		

For claims submission choose one of the following profiles:

- EXT Provider Super User
- EXT Provider Claims Submitter
- EXT Provider Eligibility Checker – Claims Submitter



# Direct Data Entry Claims (DDE)

- From the Provider Portal select the "Online Claims Entry" option located under the "Claims" heading.



# Direct Data Entry Claims (DDE)

- Choose the type of claim that you would like to submit.
  - ✓ Professional is the CMS 1500
  - ✓ Institutional is the UB04
  - ✓ Dental is the 2006 ADA form

Choose an Option.	
Submit Professional	Submit Professional
Submit Institutional	Submit Institutional
Submit Dental	Submit Dental

# Direct Data Entry Claims (DDE)

Close Save Claim Submit Claim Reset

**Professional Claim:**

Note: asterisks (\*) denote required fields. Billing Instructions

**Basic Claim Info** Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

Submitter ID: 200320900

**PROVIDER INFORMATION**

Go to Other Claim Info to enter information for Referring, Purchasing, Supervising and other providers.

**BILLING PROVIDER**

\* Provider NPI:  \* Taxonomy Code:

? \* Is the Billing Provider also the Rendering Provider? ☐ Yes ☐ No

? \* Is this service the result of a referral? ☐ Yes ☐ No Top

**SUBSCRIBER/CLIENT INFORMATION**

**SUBSCRIBER/CLIENT**

\* Client ID:

+ Additional Subscriber/Client Information

? Is this claim for a Baby on Mom's Client ID? ☐ Yes ☐ No

? \* Is this a Medicare Crossover Claim? ☐ Yes ☐ No Top

+ **OTHER INSURANCE INFORMATION**

**CLAIM INFORMATION**

Go to Other Claim Info to include the following claim detail information:  
Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.

+ **PRIOR AUTHORIZATION**

+ **CLAIM NOTE**

+ **EPSDT INFORMATION**

+ **CONDITION INFORMATION**

# Direct Data Entry Claims (DDE)

? \* Is this claim accident related?
☐ Yes ☐ No

**CLAIM DATA**
  
Patient Account No.: 
  
\* Place of Service: 
  
+ **Additional Claim Data**
  
Diagnosis Codes: \* 1:  2:  3:  4:  5:  6: 
  
7:  8:  9:  10:  11:  12:

**BASIC LINE ITEM INFORMATION**
  
Click on Other Svc Info in each line item to include the following additional line item information:  
Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

**BASIC SERVICE LINE ITEMS**
  
\* Service Date From:   
  
Place of Service: 
  
\* Procedure Code: 
  
\* Submitted Charges: \$ 
  
\* Units: 
  
+ **Medicare Crossover Items**
  
National Drug Code: 
  
+ **Drug Identification**
  
+ **Prior Authorization**
  
+ **Additional Service Line Information**

\* Service Date To:   
  
Modifiers: 1:  2:  3:  4: 
  
Diagnosis Pointers: \*1:  2:  3:  4:

**Note:** Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Add Service Line Item Update Service Line Item

# Billing Provider Information

## ➤ Section 1: Billing Provider Information of the DDE Professional claim form

**Professional Claim:**

Note: asterisks (\*) denote required fields.

**Basic Claim Info**    Other Claim Info

Billing Provider | Rendering Provider | Subscriber | Claim | Service

**PROVIDER INFORMATION**

Go to [Other Claim Info](#) to enter information for Referring, Purchasing, Supervising and other providers.

**BILLING PROVIDER**

\* Provider NPI:  \* Taxonomy Code:

? \* Is the Billing Provider also the Rendering Provider? ☐ Yes ☐ No

? \* Is this service the result of a referral? ☐ Yes ☐ No


# Billing Provider Information

- Enter the Billing Provider NPI and taxonomy code
  - ✓ This will likely be the NPI and Taxonomy Code of the clinic/office where the service was performed and where you would like payment to be received.

<b>BILLING PROVIDER</b>	
* Provider NPI:	<input type="text"/>
* Taxonomy Code:	<input type="text"/>

# Rendering Provider Information

- If the **"Rendering Provider"** is the same as the **"Billing Provider"** you just entered answer the question **"YES"** and go on to the next question.

 \* Is the Billing Provider also the Rendering Provider? ☒ Yes ☐ No

- If the **"Rendering Provider"** is different than the **"Billing Provider"** you entered in the previous question, answer **"NO"** and enter the **"Rendering (Performing) Provider"** NPI and Taxonomy Code.


 \* Is the Billing Provider also the Rendering Provider? ☐ Yes ☒ No

**RENDERING (PERFORMING) PROVIDER**

\* Provider NPI:  \* Taxonomy Code:

# Referring Provider Information

- If the service **"Is"** a result of a referral answer **"Yes"** to this question and add the referring provider NPI.

 \* Is this service the result of a referral? ☒ Yes ☐ No

**REFERRING PROVIDER INFORMATION**

\* Provider NPI:  Taxonomy Code:

- **Note:** Only the provider NPI number is required for referring providers





- If the service is **"Not"** the result of a referral answer the question **"No"** and continue on to next section.

 \* Is this service the result of a referral? ☐ Yes ☒ No



# Subscriber/Client Information

## ➤ Section 2: Subscriber/Client Information

SUBSCRIBER/CLIENT INFORMATION	
<b>SUBSCRIBER/CLIENT</b>	
* Client ID: <input type="text"/>	
 <b>Additional Subscriber/Client Information</b>	
	Is this claim for a Baby on Mom's Client ID? <input type="radio"/> Yes <input type="radio"/> No
	* Is this a Medicare Crossover Claim? <input type="radio"/> Yes <input type="radio"/> No
 <b>OTHER INSURANCE INFORMATION</b>	

# Subscriber/Client Information

- Enter the Subscriber/Client ID found on the WA Medicaid medical card. This ID is a 9 digit number followed by a **“WA”**

✓ Example: 123456789WA

A screenshot of a web form titled "SUBSCRIBER/CLIENT INFORMATION". Below the title is a section labeled "SUBSCRIBER/CLIENT". Inside this section, there is a label "\* Client ID:" followed by a text input field. Below the input field is a red square icon containing a white plus sign, followed by the text "Additional Subscriber/Client Information".

**SUBSCRIBER/CLIENT INFORMATION**

**SUBSCRIBER/CLIENT**

\* Client ID:

 **Additional Subscriber/Client Information**

- Click on the red **“+”** to expand the **“Additional Subscriber/Client Information”** to enter required information.

# Subscriber/Client Information

➤ Once the field is expanded enter the **“Patient’s Last Name, Date of Birth, and Gender”**.

✓ Date of birth must be in the following format:

**MM/DD/CCYY.**

✓ Additional shown information fields are not needed.

The screenshot shows a web form titled "SUBSCRIBER/CLIENT INFORMATION". Under the "SUBSCRIBER/CLIENT" section, there is a required field for "Client ID". Below this is an expandable section titled "Additional Subscriber/Client Information". Inside this section, there are several fields: "Org/Last Name" and "First Name" (both required), "Date of Birth" (required, with mm, dd, ccyy labels and a dropdown arrow), "Gender" (required, with a dropdown arrow), "Date of Death" (with mm, dd, ccyy labels), "Patient Weight" (with a unit of lbs), and a "Patient is pregnant" section with "Yes" and "No" radio buttons.

**SUBSCRIBER/CLIENT INFORMATION**

**SUBSCRIBER/CLIENT**

\* Client ID:

☐ **Additional Subscriber/Client Information**

\* Org/Last Name:  First Name:

\* Date of Birth:    \* Gender:

Date of Death:    Patient Weight:  lbs

Patient is pregnant: ☐ Yes ☐ No

# Baby on Mom's Client ID

- If claim is for a baby being billed under the mom's ID select "**Yes**" otherwise choose "**No**" and continue to next question.




Is this claim for a Baby on Mom's Client ID?

☐ Yes ☐ No

- **Note:** If claim is for a baby using the mom's ID, use the baby's last name, the baby's date of birth, and gender when filling out the "**Subscriber/Client**" information on previous slide. Be sure to add the claim note **SCI=B** when billing for a baby using mom's ID.

# Medicare Crossover Claim

- If the claim is considered a Medicare Crossover answer the question **"YES"**, this includes Managed Medicare Advantage Plans (Medicare Part C)

 \* Is this a Medicare Crossover Claim? ☒ Yes ☐ No

**Medicare Cross Over Items**

* Amount Paid by Medicare: \$	<input type="text"/>	* Medicare Deductible: \$	<input type="text"/>
* Medicare Co-insurance: \$	<input type="text"/>	* Medicare Allowed Amount: \$	<input type="text"/>
* Medicare Adjudication Date:	<input type="text"/> mm <input type="text"/> dd <input type="text"/> cyy	<b>Note: We have recorded a webinar specific to Medicare Crossovers located at:</b> <a href="http://hrsa.dshs.wa.gov/provider/training.shtml">http://hrsa.dshs.wa.gov/provider/training.shtml</a>	
	<input type="text"/>		

- **Note:** WA Medicaid considers a claim as a crossover when Medicare allows the service. If Medicare makes a payment, a co-pay/coinsurance should be indicated or if the charges are applied to a deductible, Medicare may not make any payment.

- If Medicare did not make a payment answer the question **"NO"**

# Insurance Other Than Medicaid

- If the client has other commercial insurance open the **“Other Insurance Information”** section by clicking on the red (+) expander.



**Other Insurance Information**

- Then open up the **“1 Other Payer Insurance Information”** section by clicking on the red (+) expander.



**Other Insurance Information**



**1 Other Payer Insurance Information**

# Insurance Other Than Medicaid

- Enter the **“Payer/Insurance Organization Name”** then
- Open up the **“Additional Other Payer Information”** section by clicking on the red (+) expander.



The screenshot shows a web form with the following structure:

- ☐ OTHER INSURANCE INFORMATION
  - ☐ 1 OTHER PAYER INSURANCE INFORMATION
    - ☒ Other Subscriber Information
    - ☒ Secondary ID Information
    - ☒ Other Insurance Coverage
    - ☒ Medicare Outpatient Adjudication Information
    - Other Payer Information

\* Payer/Insurance Organization Name:
    - ☒ Additional Other Payer Information

The "Other Payer Information" section is highlighted with a red border.

# Insurance Other Than Medicaid

- In the **“Additional Other Payer Information”** section fill in the following:

**Other Payer Information**

\* Payer/Insurance Organization Name:

☐ **Additional Other Payer Information**

Entity Qualifier:

\* ID:  \* ID Type:

Claim Check or Remittance Date:

Number Type:  PA/Referral No.:

Payer Claim Adjustment: ☐ Yes ☐ No

☐ **Secondary ID Information**

Enter the Insurance ID number, ID Type, and processing date of the insurance EOB



# Insurance Other Than Medicaid

- Use the Insurance Carrier Code found on the client eligibility screen under the **“Coordination of Benefits”** section as the **“ID”** number for the insurance company, or
- Use the assigned insurance company ID provided on the insurance EOB

Coordination of Benefits Information

Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Insurance Co. Name & Contact ▲ ▼	Carrier Code ▲ ▼	Policy Holder Name ▲ ▼	Policy Number ▲ ▼	Group Number ▲ ▼	Plan Sponsor ▲ ▼	Start Date ▲ ▼	End Date ▲ □
30: Health Benefit Plan Coverage	C1: Commercial	PREMERA BLUE CROSS/BCBS OF AK (800) 345-6784	BC01	SUPER MAN	100883158			03/01/2007	12/31/2999

- See the list of carrier codes at web page <http://hrsa.dshs.wa.gov/Download/hcarrier.txt>

# Insurance Other Than Medicaid

- Enter the total amount paid by the commercial private insurance.

— **COB Monetary Amounts**

COB Payer Paid Amount:

 **Additional COB Information**

Note: If the insurance applied to the deductible enter a \$0 here.

Note: If the claim is for an insurance denial enter a \$0 here.

# Insurance Other Than Medicaid

➤ Click on the red “+” to expand the “**Claim Level Adjustments**” section.

**Other Payer Information**  
\* Payer/Insurance Organization Name:   
☐ **Additional Other Payer Information**  
Entity Qualifier:   
\* ID:  \* ID Type:   
Claim Check or Remittance Date:  mm  dd  ccyy  
Number Type:  PA/Referral No.:   
Payer Claim Adjustment: ☐ Yes ☐ No  
☐ **Secondary ID Information**

**COB Monetary Amounts**  
COB Payer Paid Amount:   
☐ **Additional COB Information**  
☐ **CLAIM LEVEL ADJUSTMENTS**  
☐ **OTHER PAYER REFERRING PROVIDER INFORMATION**  
☐ **OTHER PAYER RENDERING PROVIDER INFORMATION**  
☐ **OTHER PAYER BILLING PROVIDER INFORMATION**  
☐ **OTHER PAYER SUPERVISING PROVIDER - SECONDARY ID INFORMATION**  
☐ **OTHER PAYER SERVICE FACILITY LOCATION INFORMATION**

# Insurance Other Than Medicaid

- Enter the adjustment **“Group Code”**, **“Reason Code”** (Number Only), and **“Amount”**

CLAIM LEVEL ADJUSTMENTS					
1 *	Group Code :	<div>CO-Contractual Obligations CR-Correction and Reversals OA-Other adjustments PI-Payer Initiated Reductions PR-Patient Responsibility</div>	* Reason Code :	* Amount :	Quantity :
2	Group Code :		Reason Code :	Amount :	Quantity :
3	Group Code :		Reason Code :	Amount :	Quantity :
4	Group Code :		Reason Code :	Amount :	Quantity :
5	Group Code :		Reason Code :	Amount :	Quantity :

Note: The Agency only accepts the standardized HIPAA compliant group and reason codes. These can be located at the following website: <http://www.wpc-edl.com/reference/>

# Claim Information

## ➤ Section 3: Claim Information Section

**CLAIM INFORMATION**

Go to [Other Claim Info](#) to include the following claim detail information:  
Specialized Line Services, Miscellaneous Line Data, Line Level Providers, Miscellaneous Line Dates, Test Results or Form Identification Information.

☐ **PRIOR AUTHORIZATION**

☐ **CLAIM NOTE**

☐ **EPSDT INFORMATION**

☐ **CONDITION INFORMATION**

☒ **\* Is this claim accident related?** ☐ Yes ☐ No

**CLAIM DATA**

Patient Account No.:

\* Place of Service:

☒ **Additional Claim Data**

Diagnosis Codes: \* 1:  2:  3:  4:  5:  6:

7:  8:  9:  10:  11:  12:

# Prior Authorization

- If a “**Prior Authorization**” number needs to be added to the claim, click on the red “+” to expand the “**Prior Authorization**” fields.
- Expedited Prior Authorization (EPA) numbers are considered authorization numbers and should be entered here.

☐ **PRIOR AUTHORIZATION**

1. \*

Prior Authorization Number:

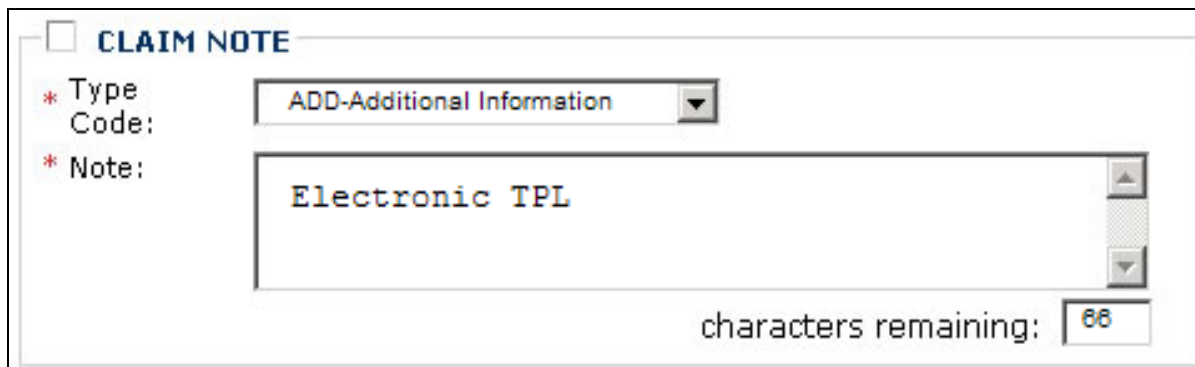
➤ Note: We recommend that providers enter any authorization number in these boxes. Entering the number here will cover the entire claim.

# Claim Note

➤ A note may be added to the claim to assist in the processing.




- Click on the red "+" to expand the **"Claim Note" section.**
- ✓ Enter the type Code **"ADD-Additional Information"**.
  - ✓ The note must say **"Electronic TPL"** if no EOB is sent.
  - ✓ The note could say **"Sending ins. EOB"** if the EOB is sent
  - ✓ ProviderOne allows up to 80 characters.

A screenshot of a web form titled "CLAIM NOTE" with a checkbox. Below the title, there are two fields. The first is labeled "\* Type Code:" and has a dropdown menu showing "ADD-Additional Information". The second is labeled "\* Note:" and has a large text area containing the text "Electronic TPL". To the right of the text area are up and down arrow buttons. At the bottom right of the form, it says "characters remaining:" followed by a small box containing the number "66".

# Is the Claim Accident Related?

➤ This question will always be answered **“NO”** as Washington Medicaid has a specific casualty office that handles claims where another casualty insurance may be primary.

✓ The Casualty office can be reached at 1-800-562-3022 extension 15462

 \* Is this claim accident related?

☐ Yes ☐ No



# Patient Account Number


- The “**Patient Account No.**” field allows the provider to enter their internal patient account numbers assigned to the patient by their practice management system.

**Patient Account No.:**

- Note: Entering internal patient account numbers may make it easier to reconcile the weekly remittance and status report (RA) as these numbers will be posted on the RA.

# Place of Service

- With 5010 implementation the **“Place of Service”** box has been added to the main claim section. Choose the appropriate **“Place of Service”** from the drop down.

\* Place of Service:  

01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE CARE FACILITY (ICF/MR)
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY	24-AMBULATORY SURGICAL CENTER	55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY	25-BIRTHING CENTER	56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
08-TRIBAL 638 PROVIDER-BASED FACILITY	26-MILITARY TREATMENT FACILITY	57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
09-PRISON/CORRECTIONAL FACILITY	31-SKILLED NURSING FACILITY (SNF)	60-MASS IMMUNIZATION CENTER
11-OFFICE	32-NURSING FACILITY	61-COMPREHENSIVE INPATIENT REHAB FACILITY
12-Home	33-CUSTODIAL CARE FACILITY	62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
13-ASSISTED LIVING FACILITY	34-Hospice	65-END-STAGE RENAL DISEASE TREATMENT FACILITY
14-Group Home	41-AMBULANCE - LAND	71-PUBLIC HEALTH CLINIC
15-MOBILE UNIT	42-AMBULANCE - AIR OR WATER	72-RURAL HEALTH CLINIC (RHC)
16-TEMPORARY LODGING	49-INDEPENDENT CLINIC	81-INDEPENDENT LABORATORY
17-WALK-IN RETAIL HEALTH CLINIC	50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	99-OTHER PLACE OF SERVICE

- Note: The **“Place of Service”** is required in this section but can still be added to the line level of the claim. Line level is **not** required.

# Additional Claim Data

- The “**Additional Claim Data**” red (+) expander will allow the provider to enter the patient’s spenddown amount.



- If patient has a spenddown click on the red (+) expander to display the below image. Enter the spenddown amount in the “**Patient Paid Amount**” box.

A screenshot of a web-based form titled "Additional Claim Data" with a minus sign icon to its left. The form contains several fields: "Place of Service:" (dropdown), "Delay Reason Code:" (dropdown), "Provider Signature on File:" (radio buttons for Yes/No), "Special Program Type Code:" (dropdown), "Provider Accept Assignment Code:" (dropdown), "Benefits Assignment Certification:" (dropdown), "Release Of Information Code:" (dropdown), "Patient Signature Source Code:" (dropdown), "Patient Paid Amount:" (text input), "Contract Code:" (text input), "Anesthesia Related Procedure Code 1:" (text input), and "Anesthesia Related Procedure Code 2:" (text input). A red rectangular box highlights the "Anesthesia Related Procedure Code 1:" field.

# Diagnosis Codes

- Enter the appropriate ICD-9 diagnosis code or codes.

Diagnosis Codes: *	1:	<input type="text"/>	2:	<input type="text"/>	3:	<input type="text"/>	4:	<input type="text"/>	5:	<input type="text"/>	6:	<input type="text"/>
	7:	<input type="text"/>	8:	<input type="text"/>	9:	<input type="text"/>	10:	<input type="text"/>	11:	<input type="text"/>	12:	<input type="text"/>

## ➤ Note:

- ✓ At least 1 diagnosis code is required for all claims.
- ✓ ProviderOne will allow up to 12 ICD-9 diagnosis codes.
- ✓ Do not enter decimal points in DX codes. ProviderOne will add these in once the claim is submitted.

# Basic Service Line Items

## ➤ Section 4: Basic Line Item Information

### BASIC LINE ITEM INFORMATION

Click on Other Svc Info in each line item to include the following additional line item information: Attachment, Drug, DMERC Condition, Health Services, Test Results, Home Oxygen Therapy, Service Facility, Miscellaneous Numbers, Indicators, Providers, Dates and Amounts, Medical Equipment, Ambulance Transport, Line Item Note, Other Payer, Spinal Manipulations, Purchased Services and Line Adjudication.

#### BASIC SERVICE LINE ITEMS

Service Date From: mm dd cyyy

Service Date To: mm dd cyyy

Place of Service:

Procedure Code:

Submitted Charges: \$

Units:

Modifiers: 1:  2:  3:  4:

Diagnosis Pointers: 1:  2:  3:  4:

☐ Medicare Crossover Items  
National Drug Code:

☐ Drug Identification  
☐ Prior Authorization  
☐ Additional Service Line Information

**Note:** Please ensure you have entered any necessary claim information (found in the other sections on this or another page) before adding this service line.

Add Service Line Item
Update Service Line Item

#### Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Line No.
Service Dates From To
Proc. Code
Modifiers 1 2 3 4
Diagnosis Ptrs 1 2 3 4
Submitted Charges
Units
PA Number

Total Submitted Charges: \$

# Basic Service Line Items

- Enter the "From Service Date"

	mm	dd	ccyy
* Service Date From:	<input type="text"/>	<input type="text"/>	<input type="text"/>


- Enter the "To Service Date"

	mm	dd	ccyy
* Service Date To:	<input type="text"/>	<input type="text"/>	<input type="text"/>

- Note: The dates of service must be in the format of 2 digit month, 2 digit day, and 4 digit year, for example 10/03/2011.

# Basic Service Line Items

- **Optional** “Place of Service Code” (Not required here as already entered)

Place of Service:  

- **Note:** Use the “Blue Arrow” drop down to display all POS codes loaded in ProviderOne.

- POS codes available:

01-PHARMACY	20-URGENT CARE FACILITY	51-INPATIENT PSYCHIATRIC FACILITY
03-SCHOOL	21-INPATIENT HOSPITAL	52-PSYCHIATRIC FACILITY - PARTIAL HOSPITALIZATION
04-HOMELESS SHELTER	22-OUTPATIENT HOSPITAL	53-COMMUNITY MENTAL HEALTH CENTER
05-INDIAN HLTH SVC FREE-STANDING FACILITY	23-EMERGENCY ROOM - HOSPITAL	54-INTERMEDIATE CARE FACILITY (ICF/MR)
06-INDIAN HLTH SVC PROVIDER-BASED FACILITY	24-AMBULATORY SURGICAL CENTER	55-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
07-TRIBAL 638 FREE-STANDING FACILITY	25-BIRTHING CENTER	56-PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
08-TRIBAL 638 PROVIDER-BASED FACILITY	26-MILITARY TREATMENT FACILITY	57-NON-RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
09-PRISON/CORRECTIONAL FACILITY	31-SKILLED NURSING FACILITY (SNF)	60-MASS IMMUNIZATION CENTER
11-OFFICE	32-NURSING FACILITY	61-COMPREHENSIVE INPATIENT REHAB FACILITY
12-Home	33-CUSTODIAL CARE FACILITY	62-COMPREHENSIVE OUTPATIENT REHAB FACILITY
13-ASSISTED LIVING FACILITY	34-Hospice	65-END-STAGE RENAL DISEASE TREATMENT FACILITY
14-Group Home	41-AMBULANCE - LAND	71-PUBLIC HEALTH CLINIC
15-MOBILE UNIT	42-AMBULANCE - AIR OR WATER	72-RURAL HEALTH CLINIC (RHC)
16-TEMPORARY LODGING	49-INDEPENDENT CLINIC	81-INDEPENDENT LABORATORY
17-WALK-IN RETAIL HEALTH CLINIC	50-FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	99-OTHER PLACE OF SERVICE

# Basic Service Line Items

- Enter the "Procedure Code"

\* Procedure Code:

➤ Note: Use current codes listed in the coding manuals.

- Enter the appropriate procedure "**Modifier(s)**" if needed.

Modifiers:

1:

2:

3:

4:

➤ Note: ProviderOne allows up to 4 Modifiers to be added to a single procedure code.



# Basic Service Line Items

## ➤ Enter **"Submitted Charges"**

\* Submitted Charges: \$

➤ Note: If dollar amount is a whole number no decimal point is needed.

➤ Note: The Agency request providers to enter their usual and accustom charges here. If providers have billed a Commercial Insurance or Medicare primary, please enter the same charges here as billed to the primary. If a provider is billing for DME supplies that required prior authorization, please enter the same amount here as was on the authorization request because they must match.

# Basic Service Line Items

- Enter appropriate "Diagnosis Pointer"

Diagnosis Pointers:      \*1:  2:  3:  4:

1  
10  
11  
12  
2  
3  
4  
5  
6  
7  
8  
9

- **Note:**

- ✓ At least one DX pointer is required.
- ✓ Up to 4 DX codes can be added per service line.
- ✓ Diagnosis Pointer 1 is the primary DX code.
- ✓ Diagnosis Pointer drop down corresponds with DX codes entered previously.

# Basic Service Line Items

- Enter procedure "Units"

\* Units:

- Note: At least 1 unit is required

# Basic Service Line Items

➤ If the claim is a “Medicare Crossover” claim complete the following:

+ Medicare Crossover Items					
* Medicare Deductible:	\$	<input type="text"/>	* Medicare Coinsurance:	\$	<input type="text"/>
* Medicare Paid:	\$	<input type="text"/>	* Medicare Allowed Amount:	\$	<input type="text"/>
* Medicare Paid Date:	mm	dd	ccyy		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		

➤ Note: Entering the line level Medicare information is required here if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

➤ Note: For complete instructions on how to submit a Medicare Crossover claim please view the online webinar and presentation slides at <http://hrsa.dshs.wa.gov/provider/training.shtml>

# Basic Service Line Items

- Enter “**National Drug Code**” (NDC) if billing an injectable procedure code.

National Drug Code:

- The “**Drug Identification**” red (+) expander is not needed when billing for injectable procedure codes.



**Drug Identification**

# Basic Service Line Items

- If a “**Prior Authorization**” number needs to be added to a line level procedure code, click on the red “+” to expand the “**Prior Authorization**” option.



**PRIOR AUTHORIZATION**

- Note: If a Prior Authorization number was entered previously on the claim it is not necessary to enter it again here.

- The “**Additional Service Line Information**” is not needed for claims submission.



**Additional Service Line Information**

# Add Service Line Items

- Click on the **“Add Service Line Item”** button to list the procedure line on the claim.

Add Service Line Item

Update Service Line Item

Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 75.00

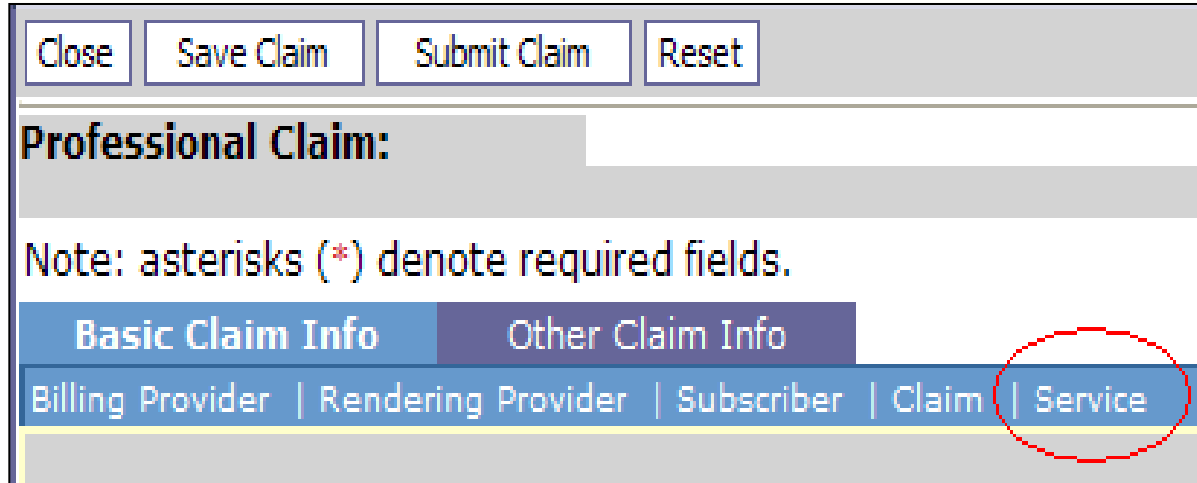
Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				75.00	1		<a href="#">Delete or Other Service Info</a>

- Note: Please ensure all necessary claim information has been entered before clicking the **“Add Service Line Item”** button to add the service line to the claim.

- Note: Once the procedure line item is added, ProviderOne will refresh and return to the top of the claim form.

# Add Additional Service Line Items

- If additional service lines need to be added, click on the **“Service”** hyperlink to get quickly back to the **“Basic Service Line Items”** section.



The screenshot shows a web form interface. At the top, there are four buttons: "Close", "Save Claim", "Submit Claim", and "Reset". Below these buttons is a section titled "Professional Claim:". Underneath this title is a large text area. A note states: "Note: asterisks (\*) denote required fields." Below the note are two tabs: "Basic Claim Info" (which is active) and "Other Claim Info". Under the "Basic Claim Info" tab, there is a horizontal menu with five items: "Billing Provider", "Rendering Provider", "Subscriber", "Claim", and "Service". The "Service" item is circled in red, indicating it is the next step in the process.

- Then follow the same procedure as outlined above for entering data for each line.



# Update Service Line Items

- Update a previously added service line item by clicking on the line number of line that needs to be updated. This will repopulate the service line item boxes for changes to be made.

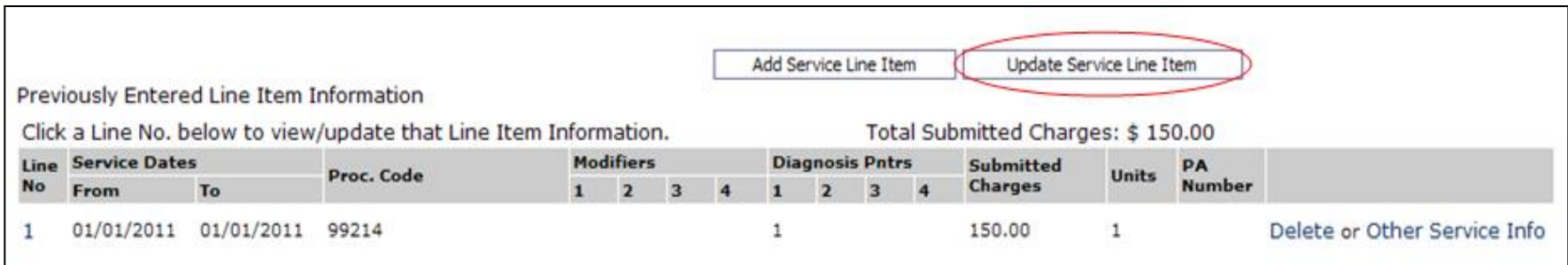
Click a Line No. below to view/update that Line Item Information. Total Submitted Charges: \$ 75.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				75.00	1		<a href="#">Delete or Other Service Info</a>

- Note: Once the line number is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the "Service" hyperlink to quickly return to the service line item boxes and make corrections.

# Update Service Line Items

- Once the service line is corrected, click on the **“Update Service Line Item”** button to add corrected information on claim.



Previously Entered Line Item Information

Click a Line No. below to view/update that Line Item Information.

Total Submitted Charges: \$ 150.00

Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntns				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				150.00	1		<a href="#">Delete or Other Service Info</a>

- Note: Once the **“Update Service Line Item”** button is chosen, ProviderOne will refresh screen and return to the top of the claim form. Use the **“Service”** hyperlink to quickly return to the service line item section to view and verify that changes were completed.

# Delete Service Line Items

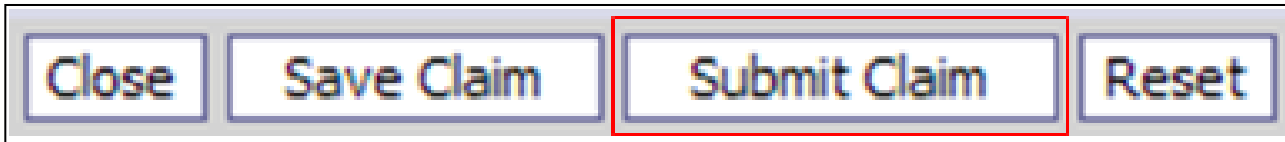
- A service line can easily be **“Deleted”** from claim before submission by clicking on the **“Delete”** option at the end of the added service line.

Click a Line No. below to view/update that Line Item Information.												Total Submitted Charges: \$ 150.00			
Line No	Service Dates		Proc. Code	Modifiers				Diagnosis Pntrs				Submitted Charges	Units	PA Number	
	From	To		1	2	3	4	1	2	3	4				
1	01/01/2011	01/01/2011	99214					1				150.00	1		<a href="#">Delete</a> or Other Service Info

- Note: Once the service line item is deleted it will be permanently removed from claim. If the service line was accidentally deleted the provider will need to re-enter the information following previous instructions.

# Submit Claim for Processing

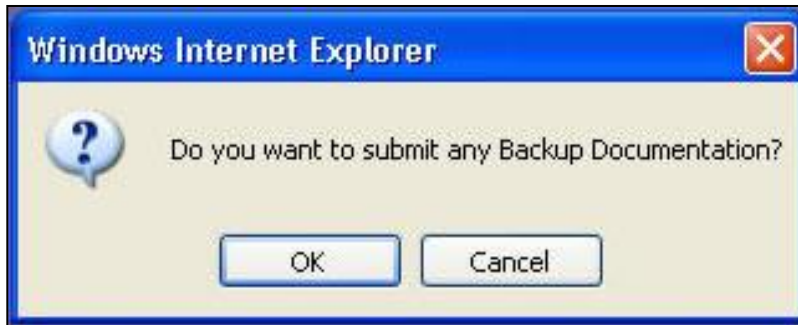
- When the claim is ready for processing, click the “**Submit Claim**” button at the top of the claim form.



- Note: Make sure the browser “**Pop Up Blocker**” is **OFF** or the system will not allow the claim to be submitted.

# Submit Claim for Processing

- After the **"Submit Claim"** button is pushed the following **"Pop Up"** is displayed



- Click on the **"Cancel"** button if no backup is to be sent.
- Click on **"OK"** if backup needs to be attached.

➤ Note: If all insurance information has been entered on the claim, it is not necessary to send the insurance EOB with the claim.

# Submit Claim for Processing – No Backup

- ProviderOne now displays the “Submitted Professional Claim Detail” screen
- Click on the “OK” button to finish submitting the claim

Claims Submission Final Dialog - Windows Internet Explorer

Submitted Professional Claim Details:

TCN: 200925500000001000  
Provider NPI: 5522336671  
Client ID: 198333777WA  
Date of Service: 9/9/2009 0:0:0-9/9/2009 0:0:0  
Total Claim Charge: 1159

Please click "Add Attachment" button, to attach the documents.

Attachment List:

Line No	File Name	Attachment Type	Transmission Code	Attachment Control	File Size	Delete	Uploaded On
No Records Found !							

Print

**WARNING: You must click the OK button to complete the claims submission.**

# Submit Claim for Processing – With Backup (Electronic File Attached)

- The “**Claims Backup Documentation**” page is displayed

The screenshot shows a web browser window titled "Windows Internet Explorer". The address bar is empty. Below the address bar, there is a message: "Please select one of the options from the Required Fields \* and select Line No, if the attachment is for a specific Service Line item." Below this message, there are three input fields: "Attachment Type:" with a dropdown menu, "Transmission Code:" with a dropdown menu, and "Line No:" with a dropdown menu. Below these fields, there is another message: "Please attach the File(s). The File Format must be PDF, DOC, TIF, XLS:". Below this message, there is a "Filename:" label followed by a text input field and a "Browse..." button. A red arrow points down to the "OK" button at the bottom right of the form. The "Cancel" button is also visible next to the "OK" button.

- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - EL-Electronic Only or Electronic file,
  - Then browse to find the file name
- ✓ Click the “**OK**” button

# Submit Claim for Processing – With Backup (Electronic File Attached)

- The “**Submitted Professional Claim Details**” page is then displayed.

**Submitted Professional Claim Details:**

TCN: 201201100000004000  
Provider NPI: 1760562995  
Client ID: 100666385WA  
Date of Service: 01/01/2012-01/01/2012  
Total Claim Charge: 120


Please click "Add Attachment" button, to attach the documents. Add Attachment

**Attachment List:**

<input type="checkbox"/>	Line No ▲ ▼	File Name ▲ ▼	Attachment Type ▲ ▼	Transmission Code ▲ ▼	Attachment Control ▲ ▼	File Size ▲ ▼	Delete ▲ ▼	Uploaded On ▲ ▼
<input type="checkbox"/>	0	10-86.pdf	EB	EL		266kb	X	01/11/2012

<< Prev Viewing Page 1 Next >>  Go Page Count SaveToXLS

Print Print Cover Page Ok

**WARNING: You must click the OK button to complete the claims submission.** 

- Now push the “**OK**” button to submit the claim.



# Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- The “**Claims Backup Documentation**” page is displayed.

Windows Internet Explorer

Please select one of the option from the Required Fields \* and select Line No, if the attachment is for specific Service Line Item.

Attachment Type:  \* Transmission Code:  \*

Line No:

Please attach the File(s). The File Format must be PDF, DOC, TIF, XLS:

Filename:  Browse... \*

OK Cancel

- ✓ Enter the Attachment Type
- ✓ Pick one of the following Transmission Codes:
  - BM : By Mail
  - FX : Fax
- ✓ Click the “**OK**” button

# Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- If sending paper documents with the claim, at the **“Submitted Professional Claim Details”** page click on the **“Print cover Page”** button.

**Submitted Professional Claim Details:**

TCN: 201127300000014000  
Provider NPI: 1342222999  
Client ID: 300655596WA  
Date of Service: 10/20/2010-10/20/2010  
Total Claim Charge: 75


Please click "Add Attachment" button, to attach the documents. [Add Attachment](#)

**Attachment List:**

<input type="checkbox"/>	Line No ▲ ▼	File Name ▲ ▼	Attachment Type ▲ ▼	Transmission Code ▲ ▼	Attachment Control ▲ ▼	File Size ▲ ▼	Delete ▲ ▼	Uploaded On ▲ ▼
<input type="checkbox"/>	0	BM	EB	BM		0kb	X	09/30/2011

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Print Print Cover Page Ok



# Submit Claim for Processing – With Backup

➤ Fill in the boxes with the appropriate information. When completed click on the **“Print Cover Sheet”** and mail to:

Electronic Claim Back-up  
Documentation  
PO BOX 45535  
Olympia, WA 98504-5535

**OR**

Fax 1-866-668-1214

The screenshot shows a web form titled "ProviderOne ECB Attachment Submission Cover Sheet". The form contains several input fields and barcodes:

- Provider Identifier Type:** A dropdown menu with the text "select a value" and a downward arrow. Below it is the instruction "( Select identifier type )".
- Provider ID:** A text input field. Below it is the instruction "( Please enter numeric value. Length based on identifier type. )".
- TCN:** A text input field. Below it is the instruction "( Please enter 18 or 21 digit numeric value starting with 1,2,3,4 or 9. )".
- Date of Service:** A text input field. Below it is the instruction "( Please use the Date Time Picker to select date. )".
- ProviderOne Client ID:** A text input field. Below it is the instruction "( Please enter 9 digit numeric value and suffix with WA or wa. )".

Each of these input fields is followed by a standard 1D barcode. To the right of the form, there is a tall, narrow barcode. At the bottom of the form, there are two buttons: "Print Cover Sheet" and "Clear Fields". Below the buttons, there is a line of text: "Instructions will not appear on the printed coversheet". At the very bottom, there is a line of text: "Please use the Print Cover Sheet Button Above to print ONLY." followed by "FAX to: 1-866-668-1214. THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET." and a version number "01/07/2011 Ver 2.0".

# Submit Claim for Processing – With Backup (Mailing or Faxing Backup)

- Now push the **“OK”** button to submit the claim

**Submitted Professional Claim Details:**

TCN: 201127300000014000  
Provider NPI: 1342222999  
Client ID: 300655596WA  
Date of Service: 10/20/2010-10/20/2010  
Total Claim Charge: 75

Please click "Add Attachment" button, to attach the documents. Add Attachment


**Attachment List:**

<input type="checkbox"/>	Line No ▲ ▼	File Name ▲ ▼	Attachment Type ▲ ▼	Transmission Code ▲ ▼	Attachment Control ▲ ▼	File Size ▲ ▼	Delete ▲ ▼	Uploaded On ▲ ▼
<input type="checkbox"/>	0	BM	EB	BM		0kb	X	09/30/2011

<< Prev Viewing Page 1 Next >>  Go Page Count SaveToXLS

Print Print Cover Page Ok

**WARNING: You must click the OK button to complete the claims submission.**



# Batch Secondary Electronic Billing

- The Agency is accepting secondary electronic claim billing through a clearinghouse batch or a self submitted HIPAA claim batch.
- Add the required comment "Electronic TPL" in Loop 2300 NTE Segment.
- Add the required Adjustment Reason Code information (Loop information located on the above pages in the companion guides).

# Saving a Direct Data Entry (DDE) Claim

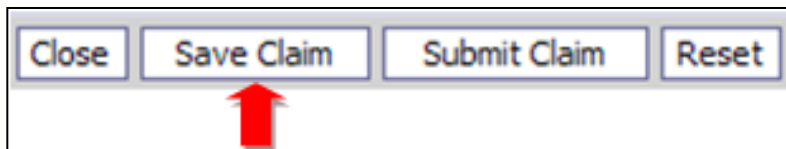
# Saving a Direct Data Entry Claim

➤ ProviderOne now allows a provider to save a claim if the provider is interrupted during the process of entering a claim, and allows retrieving that saved claim to finish and submit the claim. The following data elements are at minimum required to be completed before a claim can be saved:

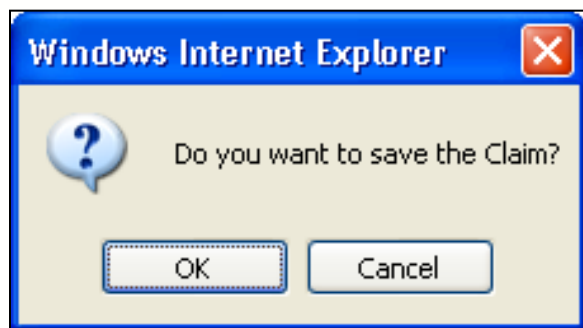
<b>Provider Information</b> <ul style="list-style-type: none"><li>• Billing Provider NPI</li><li>• Billing Provider Taxonomy</li><li>• Question: Is the Billing Provider also the Rendering Provider?</li><li>• Question: Is this service the result of a referral?</li></ul>	<b>Subscriber/Client Information</b> <ul style="list-style-type: none"><li>• Client ID number</li><li>• Question: Is this a Medicare Crossover Claim?</li></ul>
<b>Claim Information</b> <ul style="list-style-type: none"><li>• Question: Is this claim accident related?</li></ul>	<b>Basic Service Line Items</b> <ul style="list-style-type: none"><li>• Line Items are not required for saving a claim.</li></ul>

# Saving a Direct Data Entry Claim

- Save the claim by clicking on the "Save Claim" button.



- ProviderOne now displays the following confirmation box:



- Click the "**OK**" button to proceed or Cancel to return to the claim form.
- Once the "**OK**" button is clicked, ProviderOne checks the claim to make sure the minimum data fields are completed.
- If all data fields are completed, ProviderOne saves the claim and closes the claim form.



# Retrieving a Saved Direct Data Entry Claim

- At the Provider Portal, click on the “Retrieve Saved Claims” hyperlink



# Retrieving a Saved Direct Data Entry Claim

➤ ProviderOne displays the Saved Claims List.

✓ Click on the “**Link**” Icon to retrieve a claim.

<input type="checkbox"/>	Link	Billing Provider NPI	Client ID	Client Last Name	User Login ID
<input type="checkbox"/>	▶	552233661	198333777WA		BettyB
<input type="checkbox"/>	▶	552233661	198333666WA	Rogers	Bob5

➤ The system loads the saved claim in the correct DDE claim form screen. Continue to enter data, then submit the claim.

➤ Once a saved claim has been retrieved and submitted, it will be removed from the Saved Claim List.

# Medicare Crossover

# Medicare Crossover Claims

## Learning Objectives:

- After this training, you will be able to:
  - ✓ Verify if a Client has Medicare and determine the type of coverage they have
  - ✓ Bill Medicare crossovers on professional and institutional claim formats electronically
  - ✓ Better understand the Payment Methodology for Medicare parts A, B, and C
  - ✓ Learn tips on billing crossovers successfully

# Common Terminology

## ➤ Coinsurance

- ✓ An amount a Medicare client may be required to pay as their share of the cost for services.

## ➤ Deductible

- ✓ The amount for which a beneficiary is responsible before Medicare starts paying.

## ➤ Capitated Copayment

- ✓ A predetermined set dollar amount a Medicare client may be required to pay as their share of the cost for services.

## ➤ Non-Capitated Copayment

- ✓ An amount a Medicare client may be required to pay as their share of the cost for services.

# Overview – Medicare Crossover

- There are 4 types of Medicare coverage:
  - ✓ Medicare **Part A** Inpatient hospital services
  - ✓ Medicare **Part B** Covers professional and vendor services
  - ✓ Medicare **Part C** Managed Care version of Medicare, a Medicare Advantage Plan
  - ✓ Medicare **Part D** Covers prescription drugs
- When is a claim a Medicare Crossover claim?
  - ✓ If Medicare pays or applies to the deductible, the claim billed to HCA is a crossover.
  - ✓ The general rule is to bill the Agency after Medicare on the same claim form billed to Medicare.
  - ✓ The Agency is not paying **Part D** co-pays. (Part D is not covered in this presentation)

# Overview - Medicare Crossovers

- When is a claim **NOT** a crossover claim?
  - ✓ Claims (services) denied by Medicare when billed to us are not crossover claims.
  - ✓ We still require the Medicare EOB to demonstrate non-payment.
- Sometimes Medicare does **NOT** forward claims automatically to the Agency
  - ✓ Can submit in Direct Data Entry or Electronically without the EOMB.
  - ✓ The Medicare Advantage Plans do not cross claim directly so they must be billed as crossover claims.

# Overview - Medicare Crossovers

- If Medicare denies a Medical Assistance-covered service that requires Prior Authorization, the service still requires authorization
  - ✓ You may request it after the service is provided.
  - ✓ The Agency waives the “prior” requirement in this circumstance.



# Medicare Eligibility

- Eligibility checks may show Medicare as:
  - ✓ **QMB** – Medicare Only (Qualified Medicare Beneficiary)
    - This program pays for Medicare premiums and may pay deductibles, coinsurance, and copayments according to Medicaid rules.
  - ✓ **CNP-QMB** (Categorically Needy Program – Qualified Medicare Beneficiary)
    - Client has full Medicaid as well as QMB benefits.

# Medicare Eligibility

- Programs that HCA would not consider for secondary payment after Medicare
  - ✓ **SLMB** (Special Low Income Medicare Beneficiary)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ **QI-1** (Qualified Individual 1)
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.
  - ✓ **QDWI** (Qualified Disabled Working Individual) –
    - This program only pays for Medicare premiums. Health coverage through Medical Assistance Medicaid is not covered.

# Medicare Eligibility

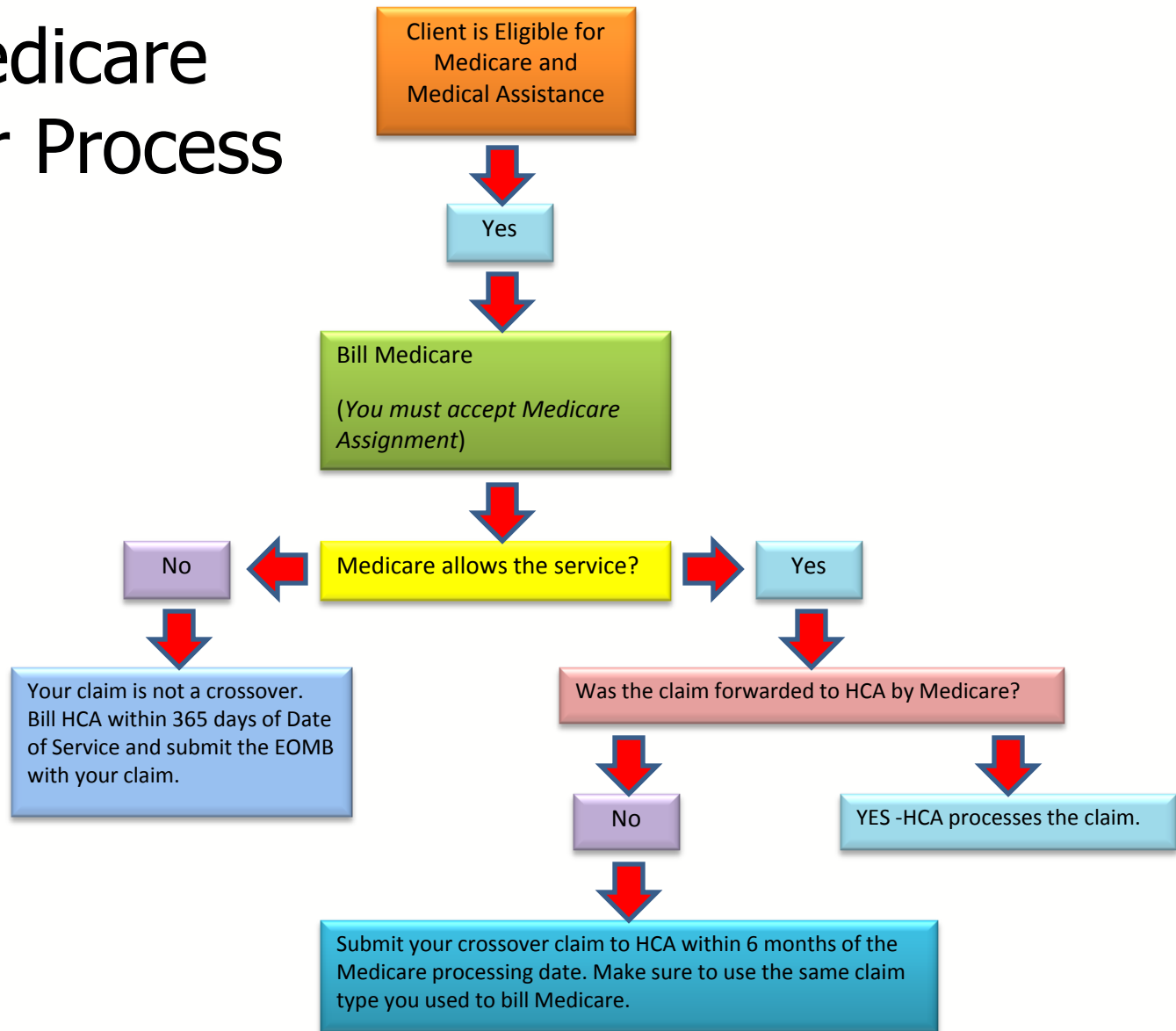
- Determine Medicare eligibility using ProviderOne

Medicare Eligibility Information			
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ □
30: Health Benefit Plan Coverage	MA: Medicare Part A	01/01/2004	12/31/2999
30: Health Benefit Plan Coverage	MB: Medicare Part B	01/01/2004	12/31/2999

- ✓ The Medicare HIC number is listed under the “Client Demographic Section”
- Medicare Part C information (if loaded) is located under the COB section

Coordination of Benefits Information									
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Insurance Co. Name & Contact ▲ ▼	Carrier Code ▲ ▼	Policy Holder Name ▲ ▼	Policy Number ▲ ▼	Group Number ▲ ▼	Plan Sponsor ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼
30: Health Benefit Plan Coverage	C1: Commercial	RXAMERICA (800) 429-6686	S5644		Med Part D			01/01/2008	12/31/2011
30: Health Benefit Plan Coverage	C1: Commercial	STERLING LIFE INSURANCE COMPANY (360) 647-9080	H5006		Med Part C			03/01/2006	12/31/2011

# The Medicare Crossover Process



# Medicare Billing Part B

# Medicare Billing – Part B

## ➤ CMS-1500, 837P

- ✓ If Medicare has paid all lines on your claim and did not forward the claim to WA Medicaid, submit the crossover claim to the Agency.
- ✓ If Medicare has allowed and denied service lines on your claim:
  - You will need to submit **TWO** claims to the Agency;
    - One crossover claim for services Medicare paid and;
    - One professional claim for services Medicare denied.

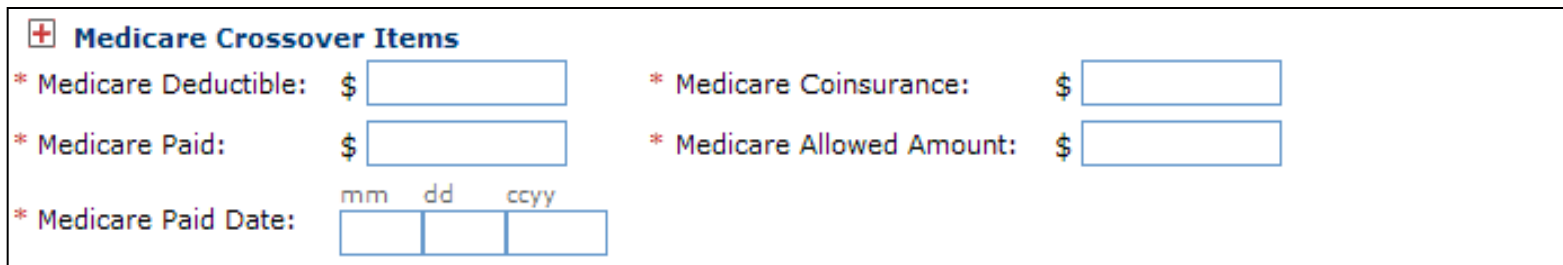
# Medicare Billing – Part B

- Bill the Agency using the same service codes and billed amounts sent to Medicare.
- Medicare and Medicare Advantage Plans are Medicare
  - ✓ HCA does not consider Medicare as insurance
- When submitting via Direct Data Entry (DDE)
  - ✓ Click the Radio button **“YES”** to indicate this claim is a crossover



Is this a Medicare Crossover Claim? ☒ Yes ☐ No

- ✓ Additional data boxes open to be filled in as required at claim level.



**Medicare Crossover Items**

* Medicare Deductible:	\$	<input type="text"/>	* Medicare Coinsurance:	\$	<input type="text"/>
* Medicare Paid:	\$	<input type="text"/>	* Medicare Allowed Amount:	\$	<input type="text"/>
* Medicare Paid Date:	mm	dd	ccyy		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		

# Medicare Billing – Part B

➤ The rest of claim information is filled out as normal down to the service line information. The Medicare line data must be entered here now.

➤ **Note:** Entering the line level Medicare information is required if the previous question concerning Medicare Crossovers was answered yes. The line level Medicare payment data sum must match the claim level Medicare payment data entered.

+ Medicare Crossover Items					
* Medicare Deductible:	\$	<input type="text"/>	* Medicare Coinsurance:	\$	<input type="text"/>
* Medicare Paid:	\$	<input type="text"/>	* Medicare Allowed Amount:	\$	<input type="text"/>
* Medicare Paid Date:	mm	dd	ccyy		
	<input type="text"/>	<input type="text"/>	<input type="text"/>		

➤ No EOB is required with the DDE crossover claim.



# Medicare Billing – Part B

## ➤ HIPAA batch 837P:

### Medicare Information

- Loop 2320 – Other Subscriber Information
  - ✓ SBR09 = **MB**

### Medicare Payment Information

- Loop 2430 – Coordination Of Benefits
  - ✓ SVD02 = Medicare Paid Amount
  - ✓ CAS01 = PR-Patient Responsibility
  - ✓ CAS02 = 1-Deductible Amount
  - ✓ CAS02 = 2-Coinsurance
  - ✓ DTP03 = Medicare Paid Date (CCYYMMDD)

# Medicare Billing Part A

# Medicare Billing – Part A

## ➤ UB-04, 837I

- ✓ If you bill Medicare using the UB-04 claim format, you would bill the Agency using the same claim format.
- ✓ Include the same services and billed amounts you sent to Medicare.

RHC note: One date of service per claim form

## ➤ Submit DDE crossover claims in ProviderOne

- ✓ Click Radio button “yes” to indicate claim is a crossover then fill in the data boxes.

?

Is this a Medicare Crossover Claim?

☒ Yes ☐ No

Medicare Cross Over Items

\* Medicare Days Covered:

\* Amount Paid by Medicare: \$

\* Medicare Co-insurance: \$

\* Medicare Adjudication Date:

mm

dd

ccyy

\* Amount Billed to Medicare: \$

\* Medicare's Inpatient Deductible: \$

\* Medicare Allowed Amount: \$

# Medicare Billing – Part A

## ➤ HIPAA batch 837I:

### Medicare Information

- ✓ Loop 2320 – Other Subscriber Information
  - SBR09 – **MA** or **MB**

### Medicare Payment Information

- ✓ Loop 2320 – Claim Level Adjustment
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
- ✓ Loop 2320 – Coordination Of Benefits
  - AMT01 = D-Medicare Amount Paid
- ✓ Loop 2330B – Claim Process Date
  - DTP03 = Medicare Paid Date (CCYYMMDD)

# Medicare Billing – Part A

## ➤ HIPAA batch 837I:

### Medicare Payment Information (continued)

- ✓ Loop 2430 = Claim Level Adjustment
  - SVD02 = Medicare Paid Amount
  - CAS01 = PR-Patient Responsibility
  - CAS02 = 1-Deductible Amount
  - CAS02 = 2-Co-Insurance
  - DTP03 = Medicare Paid Date (CCYYMMDD)

# Medicare Billing Part C

# Medicare Billing – Part C

- Some clients have elected to enroll in a Medicare HMO plan called a Medicare Advantage Plan (Part C)
  - ✓ Providers are required to bill the Med Advantage Plans.
  - ✓ Follow the billing guidelines established by the Plans.
- After the Med Advantage plan pays the claim, submit the crossover claim to Medical Assistance.
  - ✓ Bill Medical Assistance on the same claim format.
  - ✓ Make sure the services and billed amounts match what was billed to the Medicare Advantage plan.
  - ✓ No EOMB needed for DDE (it is a crossover claim).
  - ✓ The Agency must receive the Medicare Advantage claim within 6 months of the Medicare Advantage payment date.

# Medicare Billing – Part C

- If there is a **Capitated Copayment** due on claim:
  - ✓ These claims are still billed as crossover claims.
  - ✓ **Capitated Copayment** crossover claims do not require an EOB.
  - ✓ Comments are no longer required on the claim.
  - ✓ Bill just the Capitated Copayment.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at [http://www.hca.wa.gov/medicaid/billing/pages/providerone\\_billing\\_and\\_resource\\_guide.aspx](http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx)



# Medicare Billing – Part C

- If there is coinsurance, a deductible, or a **Non-Capitated Copayment** due on a claim.
  - ✓ These claims are billed as crossover claims.
  - ✓ DDE and Electronic crossover claims do not require the EOB with the claim.
  - ✓ Comments are no longer required on the claim.
  - ✓ Questions? Detailed instructions for billing are located on page 99 of the *ProviderOne Billing and Resource Guide* located at [http://www.hca.wa.gov/medicaid/billing/pages/providerone\\_billing\\_and\\_resource\\_guide.aspx](http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx)

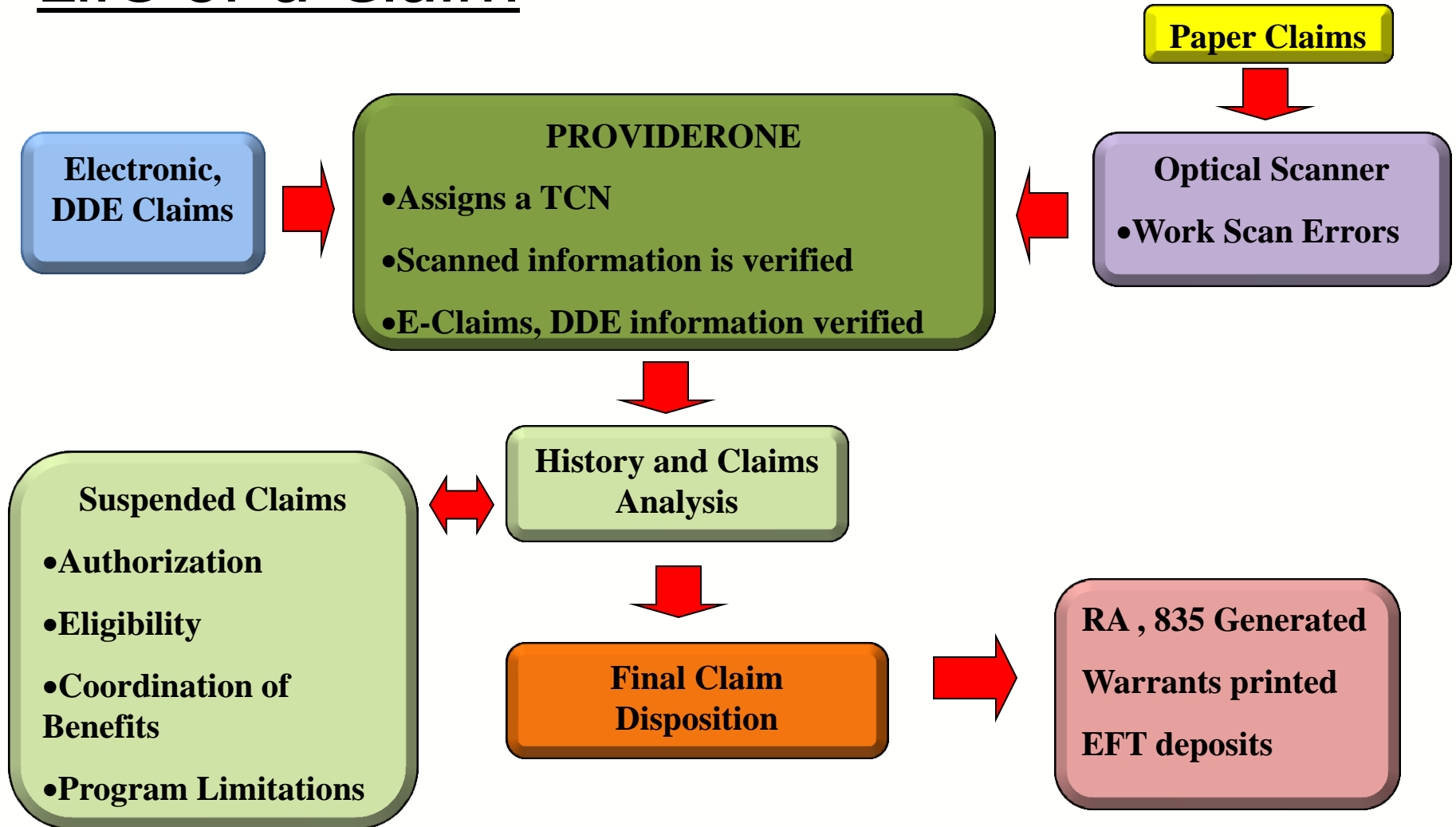
# Medicare Billing – Part C

- If the Medicare Advantage Plan does not cover the service
  - ✓ Bill the Agency for the services if the client has Medicaid medical coverage.
  - ✓ The Agency does not pay for the service if the client is only QMB eligible.
  - ✓ Discrepancies, disputes, protests should be directed to the Medicare Advantage plan.
  - ✓ If the Plan adjusts your payment and the crossover claim has been paid, you should adjust the crossover claim.
  - ✓ Submit a new crossover claim if the original claim was denied and the Plan adjustment could result in a payment.

# Tips on Billing Crossovers

- Bill your taxonomy code(s) to Medicare the same as you bill your taxonomy code(s) to Medicaid.
- There will be a claim denial due to:
  - ✓ Billing Medicare with an NPI not been reported to the Agency.
    - The Agency will not be able to identify the provider when these claims are forwarded by Medicare.
  - ✓ Billing a paper crossover claim to the Agency without a copy of the Medicare EOB attached.
  - ✓ The claim format billed to Medicare does not match the claim format billed to Medical Assistance.
  - ✓ The coding and dollar amount billed do not match (paper claims).
  - ✓ Failure to fill data in all required fields on the DDE crossover screen.

# Life of a Claim



# Claim Inquiry

# Claim Inquiry

## ➤ How do I find claims in ProviderOne?

- ✓ Choose the **"Claim Inquiry"** Option from the Provider Portal
- ✓ Enter search data then click on the **"Submit"** button.



The screenshot shows the 'Provider Claim Inquiry Search:' form. At the top, there are 'Close' and 'Submit' buttons, with a red arrow pointing to the 'Submit' button. Below the buttons is a red-bordered box containing instructions: 'Please enter a Provider NPI and enter available information in the remaining fields before clicking \'Submit\'.', followed by three bullet points: 'Required: TCN or Client ID AND Claim Service Period (To date is optional)', 'You may request status for claims processed within the past four years', and 'The Claim Service Period From and To date range cannot exceed 3 months'. Below the instructions, the form fields are: 'Provider NPI:' with a dropdown menu showing '5100000004' and an asterisk, 'TCN:' with a text input field, 'Client ID:' with a text input field, 'Claim Service Period From:' with a text input field, and 'Claim Service Period To:' with a text input field.

# Claim Inquiry

- Claim Transaction Control Number (TCN's) returned
  - ✓ Click on the **"TCN"** number to view the claim data.
  - ✓ Denied claims will show the denial codes.
  - ✓ Easiest way to find a timely TCN number for re-bills.

Claim Inquiry Providers List:

<input type="checkbox"/>	TCN ▲ ▼	Date of Service ▲ ▼	Claim Status ▲ ▼	Claim Charged Amount ▲ ▼
<input type="checkbox"/>	!1030200005720000	10/14/2010	0: Cannot provide further status electronically.	\$888.00
<input type="checkbox"/>	!1101100018152000	10/14/2010	0: Cannot provide further status electronically.	\$888.00
<input type="checkbox"/>	!1105400007698000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1106100031712000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1106600001668000	10/14/2010	1: For more detailed information, see remittance advice.	\$750.00
<input type="checkbox"/>	!1106600003011000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1107500035007000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1108200019887000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1113600005638000	10/14/2010	0: Cannot provide further status electronically.	\$750.00
<input type="checkbox"/>	!1114400017409000	10/14/2010	1: For more detailed information, see remittance advice.	\$750.00

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# Why can't I pull up my claim?!

- There are many reasons why you might not be able to retrieve a claim (for any system functions).
  - ✓ It has been Adjusted, you can't retrieve a claim that has already been Adjusted.
  - ✓ It has been replaced by another claim.
  - ✓ It hasn't finished processing.
  - ✓ It was billed under a different domain.
  - ✓ You could be using the wrong profile.
  - ✓ You submitted by batch with more than 1 NDC on a claim line.
  - ✓ Trying to do a Resubmit on a paid claim or an Adjustment to a denied claim.
  - ✓ Claims billed with an NPI not reported in ProviderOne.
  - ✓ Claims billed with an ID only rendering provider NPI number as the pay-to provider.

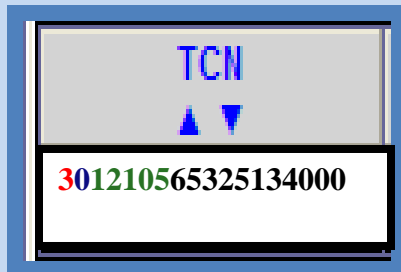


# Billing Timely

- What are the Agency's timeliness guidelines?
  - ✓ The initial billing must occur within 365 days from the date of service on the claim.
  - ✓ Providers are allowed 2 years in total to get a claim paid or adjusted.
  - ✓ For Delayed Certification client eligibility the Agency allows 12 months from the Delayed Cert date to bill.
  - ✓ Recoupment's from other payers-timeliness starts from the date of the recoupment, not the date of service.
  - ✓ Trimester care-determined from the Expected Date of Delivery (EDD), EDD must be noted on the claim.
  - ✓ The Agency uses the Julian calendar for dates.
  - ✓ Crossover and Pharmacy claims have different timeliness guidelines.

# What is a TCN?

**TCN=Transaction  
Control Number**



**18 digit number that  
ProviderOne  
assigns to each  
claim received for  
processing. TCN  
numbers are never  
repeated.**

# How do I read a TCN?

## 1<sup>st</sup> digit-Claim Medium Indicator

- 1-paper
- 2-Direct Data Entry
- 3-electronic, batch submission
- 4-system generated (Credits/Adjustment)

## 2<sup>nd</sup> digit-Type of claim

- 0-Medical
- 2-Crossover or Medical

## 3<sup>rd</sup> thru 7<sup>th</sup> digits-date claim was received

- 3<sup>rd</sup> and 4<sup>th</sup> digits are the year
- 5<sup>th</sup>, 6<sup>th</sup> and 7<sup>th</sup> digits are the day it was received

Example TCN: **301210465325134000**

**3**-electronic submission via batch

**0**-medical claim

**12**-year claim was received, 2012

**104**-day claim was received, April 13th

# How do I prove timeliness?

## ➤ HIPAA batch transaction

- ✓ Electronic submission-Professional, Institutional & Dental
  - Enter the timely TCN in the claim note, Loop 2300, segment NTE02=TCN\*

\*837I institutional has 2 NTE segments, we capture information from either segment.

## ➤ Direct Data Entry (DDE) Claims

- ✓ Resubmit Original Denied/Voided Claim; or
- ✓ Enter timely TCN in the "Claim Note"
- ✓ Enter recoupment statement in "Claim Note"  
"Recouped for SSI, 00/00/00"
- ✓ Enter EDD date in "Claim Note"

# How do I prove timeliness?

- Paper billing-CMS-1500
  - ✓ Enter timely TCN in box 22
  - ✓ Enter the recoupment date in box 19
  - ✓ Enter the EDD date in box 19
- Paper billing-UB04
  - ✓ Enter timely TCN in box 64 a-c
- Paper billing-ADA
  - ✓ Enter timely TCN in box 35

# Adjust/Void a Paid Claim

- Select "Claim Adjustment/Void" from the Provider Portal.

**Provider Claim Adjust Void Search:**

Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit'.

- Required: TCN or Client ID AND Claim Service Period (To date is optional)
- You may Adjust/Void claims processed within the past four years
- The Claim Service Period From and To date range cannot exceed 3 months
- Only paid claims satisfying the selection criterion will be returned

Provider NPI:  \*

TCN:

Client ID:

Claim Service Period From:

Claim Service Period To:

Note: Per **WAC 182-502-0150** claims can only be adjusted/voided in ProviderOne 24 months from the date of service. Prescription drug claims have only 15 months.

- Enter the TCN number if known; or
- Enter the Client ID, and the From-To date of service.

# Adjust/Void a Paid Claim

- The system will display the paid claim(s) based on the search criteria.

Close Adjust Void Claim

Provider NPI: 1134178999

Provider Claims Adjust Void List:

<input type="checkbox"/>	TCN □ ▼	Date of Service ▲ ▼	Claim Status ▲ ▼	Claim Charged Amount ▲ ▼	Claim Payment Amount ▲ ▼	Client Name ▲ ▼	Client ID ▲ ▼
<input type="checkbox"/>	5064000001000	03/13/2007	1-"For more detailed information, see remittance advice."	\$168.00	\$56.12		WA

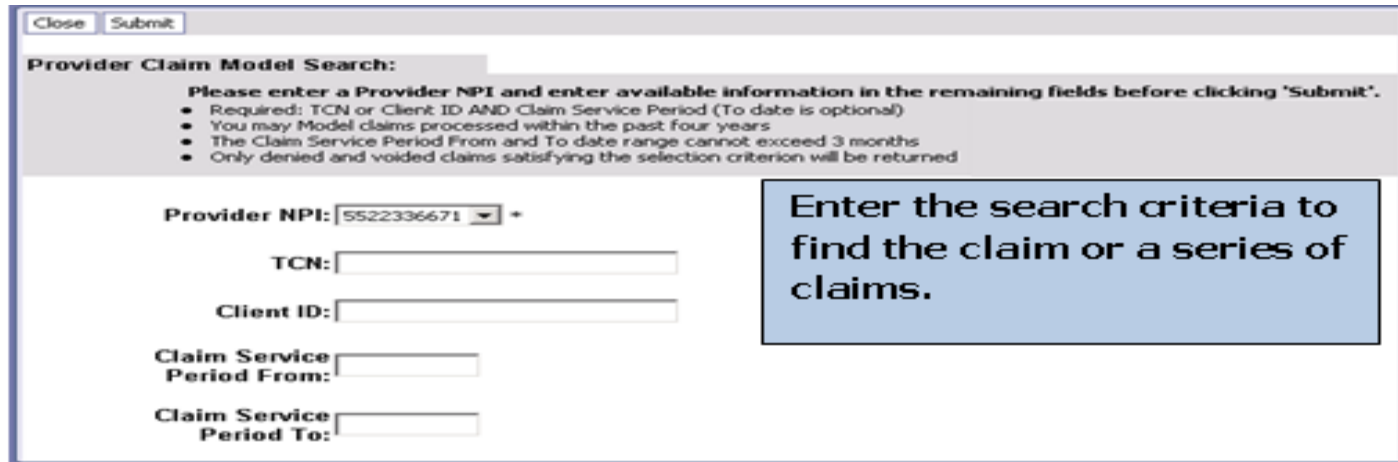
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Check the box next to the TCN to adjust

- Check the box of the TCN to adjust/void.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information to adjust, then submit.
  - ✓ Claim data can not be changed when doing a void, just submit the void.

# Resubmit a Denied Claim

- Select “Resubmit Denied/Voided Claim” from the Provide Portal.



The screenshot shows a web form titled "Provider Claim Model Search:". At the top, there are "Close" and "Submit" buttons. Below the title, a grey box contains instructions: "Please enter a Provider NPI and enter available information in the remaining fields before clicking 'Submit'." followed by four bullet points: "Required: TCN or Client ID AND Claim Service Period (To date is optional)", "You may Model claims processed within the past four years", "The Claim Service Period From and To date range cannot exceed 3 months", and "Only denied and voided claims satisfying the selection criterion will be returned". The form fields include: "Provider NPI:" with a dropdown menu showing "5522336671" and a plus sign; "TCN:" with a text input field; "Client ID:" with a text input field; "Claim Service Period From:" with a text input field; and "Claim Service Period To:" with a text input field. A blue callout box on the right side of the form contains the text: "Enter the search criteria to find the claim or a series of claims."

- A TCN will bring up only one claim.
- Enter the Client ID and the From-To dates of service to find all claims billed these dates.



# Resubmit a Denied Claim

- The system will display the claim(s) based on the search criteria.

Close Retrieve

Provider NPI: 1134178999

Provider Claims Model List:

	TCN	Date of Service	Claim Status	Claim Charged Amount	Claim Payment Amount	Client Name	Client ID
<input checked="" type="checkbox"/>	93072625558500C	09/10/2007	1: "For more detailed information, see remittance advice."	\$160.00	\$0.00	LO A	WA

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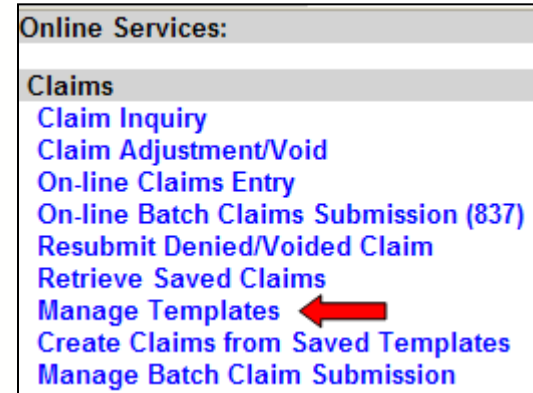
Check the box next to the TCN to resubmit

- Check the box of the TCN to resubmit.
- ProviderOne loads the DDE screen with the claim data.
  - ✓ Update the claim information that caused the claim to deny, then submit.

# Creating a Claim Template

## ➤ ProviderOne allows creating and saving templates.

- ✓ Log into ProviderOne.
- ✓ Click on the **"Manage Templates"** hyperlink.
- ✓ At the Create a Claim Template and list screen, click the **"Type of Claim"** Option.



Close Add

Create a Claim Template

Type of Claim: Institutional \* ←

Claims Template List

Edit View Delete Save As/Copy Create Batch Create Batch All Auto Batch

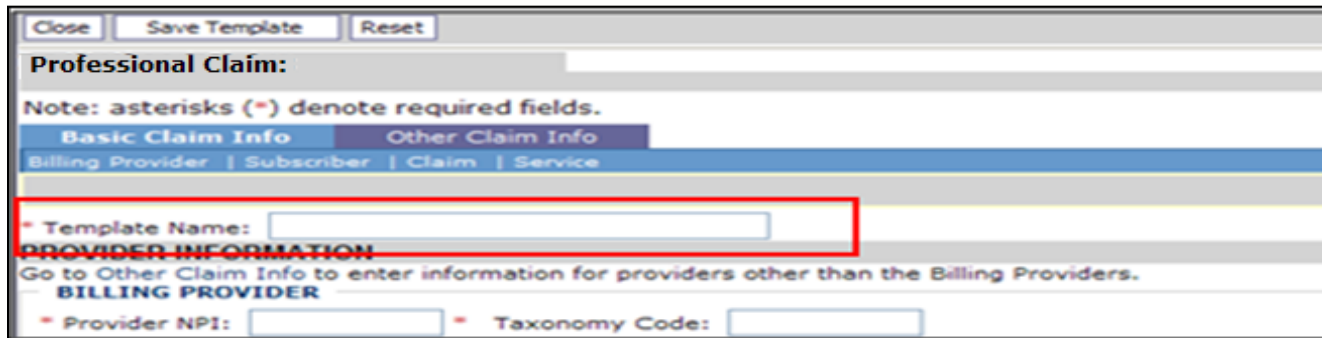
Filter By : [ ] And [ ] [ ] Go

Template Name	Type	Last Updated By	Last Updated Date
No Records Found !			

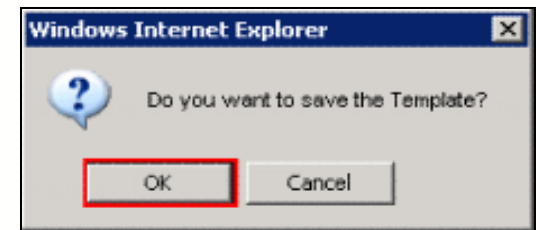
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# Creating a Claim Template

- Once a template type is picked the system opens in the DDE screen.



- Name the template then fill in as much data as wanted on the template.
- Click on the **"Save Template"** button and the system verifies you are saving the template. Click on the **"OK"** button to save template.



# Creating a Claim Template

- After the template is saved it is listed on the “**Claim Template List**”.

Close Add

Create a Claim Template

Type Of Claim: Professional

Claims Template List

Edit View Delete SaveAs/Copy Create Batch Create Batch All Auto Batch

Filter By : And Go

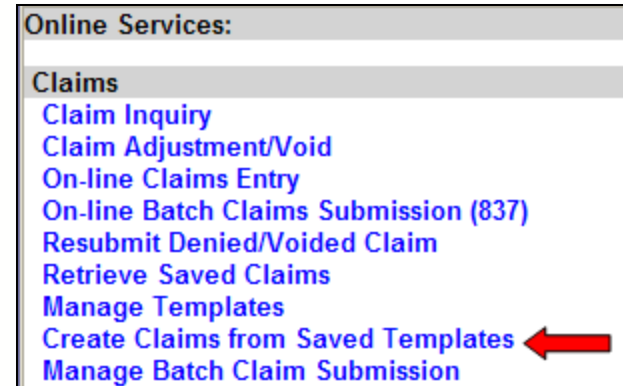
<input type="checkbox"/>	Template Name ▲ ▼	Type ▲ ▼	Last Updated By ▲ ▼	Last Updated Date ▲ ▼
<input type="checkbox"/>	template test	Professional	NolanC	08/06/2012
<input type="checkbox"/>	ginnietest	Dental	odelivm	10/15/2012
<input type="checkbox"/>	ginnietest2	Dental	odelivm	10/15/2012
<input type="checkbox"/>	JOHN SMITH1	Professional	mcnamr	01/04/2013

- Additional templates can be created:
  - ✓ Copying a template on the list; or
  - ✓ Creating another from scratch.
- Templates can be edited, viewed, and deleted.

# Submitting a Template Claim

## ➤ Claims can be submitted from a Template.

- ✓ Log into ProviderOne.
- ✓ Click on the **"Create Claims from Saved Templates"** hyperlink.
- ✓ At the Saved Template List find the template to use. (sort the list using the sort tools outlined)



Close

Create Claim from Saved Templates List:

Filter By : [ ] And [ ] [Go]

Template Name	Type	Last Updated By	Last Updated
John Smith	Institutional	GaryM	10/2/2010
Jane Doe	Institutional	GaryM	10/2/2010
Uncle Sam	Institutional	GaryM	10/2/2010
Susan Madigan	Institutional	GaryM	10/2/2010
Lisa Fax	Institutional	GaryM	10/2/2010
Roberta Thomas	Institutional	GaryM	10/2/2010
Mickey Dee	Institutional	GaryM	10/2/2010

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# Submitting a Template Claim

- Click on the Template name.
- The DDE screen is loaded with the template.

The screenshot shows a web form titled "Institutional Claim:". At the top are buttons for "Close", "Save Claim", "Submit Claim", and "Reset". Below the title is a note: "Note: asterisks (\*) denote required fields." There are two tabs: "Basic Claim Info" (selected) and "Other Claim Info". Under "Basic Claim Info", there are links for "Billing Provider", "Subscriber", "Claim", and "Service". The form is divided into sections: "PROVIDER INFORMATION" with a sub-section "BILLING PROVIDER" containing fields for "Provider NPI" (1831199966) and "Taxonomy Code" (193200000X); "SUBSCRIBER/CLIENT INFORMATION" with a sub-section "SUBSCRIBER/CLIENT" containing a field for "Client ID" (200076507WA); and an expandable section "Additional Subscriber/Client Information" with fields for "Org/Last Name" (SMITH) and "First Name" (JOHN).

- Enter or update the data for claim submission then submit the claim.
- Batches of Template Claims can be created.
- See the Batch Template webinar at <http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx>

# Reading the Remittance Advice (RA)

# Reading the Remittance Advice (RA)

## ➤ How do I retrieve the PDF file for the RA?

- ✓ Log into ProviderOne with a **Claims/Payment Status Checker, Claims Submitter, or Super User** profile.



- ✓ At the Portal click on the hyperlink **View Payment**.

- ✓ The system should open your list of RAs.

RA/ETRR Number ▲ ▼	Check Number ▲ ▼	Check/ETRR Date ▲ ▼	RA Date ▲ ▼	Claim Count ▲ ▼	Charges ▲ ▼	Payment Amount ▲ ▼	Adjusted Amount ▲ ▼	Download ▲ ▼
2444447	000777	02/23/2012	02/24/2012	1428	\$513,899.73	\$62,865.54	\$408,607.26	
2443392	000778	02/16/2012	02/17/2012	1538	\$484,679.55	\$63,959.26	\$375,030.04	
2229984	004772	02/09/2012	02/10/2012	1384	\$488,482.16	\$80,452.68	\$408,029.48	

- ✓ Click on the **RA number** in the first column to open the whole RA.



# Reading the Remittance Advice (RA)

- The Summary Page of the RA shows:
  - ✓ Billed and paid amount for Paid claims
  - ✓ Billed amount of denied claims
  - ✓ Total amount of adjusted claims
  - ✓ Provider adjustment activity

RA Number: 8765432  
Warrant/EFT # 852741!

Warrant/EFT Date: 05/29/2014

Warrant/EFT Amount: \$9325.93

Payment Method: EFT

Prepared Date: 05/30/2014  
RA Date: 05/30/2014

Page 2

## Claims Summary

## Provider Adjustments

Billing Provider	Category	Total Billed Amount	Total Allowed Amount	Total TPL Amount	Total Sales Tax	Total Client Resp Amount	Total Paid	Billing Provider	FIN Invoice Number: Parent TCN	Source	Adjustment Type	Previous Balance Amount	Adjustment Amount	Remaining Balance Amount
1122334455	Paid	\$28930.00	\$16114.57	\$0.00	\$0.00	\$0.00	\$9325.93	1122334455	214148190028/401401234567890000	System Initiated	NOC Invoice	\$0.00	\$0.00	\$3266.00
1122334455	Denied	\$6525.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	1122334455	214148190028/401498701234560000	System Initiated	NOC Referred to CARS	\$3266.00	\$3266.00	\$0.00
1122334455	Adjustments	-\$2981.00	-\$3371.87	\$0.00	\$0.00	\$0.00	-\$3266.00							
1122334455	In Process	\$5946.50	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00							

Total Adjustment Amount      \$3266.00

# Reading the Remittance Advice (RA)

- Provider Adjustments:
  - ✓ These adjustment amounts can carry over on each week's RA until the amount is paid off or reduced by the amount paid out for claims adjudicated that week.
  - ✓ Claims that caused these carry over adjustment amounts can be on previous RAs.
  - ✓ A recent update to the RA format now populates the parent TCN under the FIN Invoice Number for reference.
  - ✓ Credit balance RAs have a "check number" that looks like this: **JVAH0223344556677800**.
  - ✓ ProviderOne automatically sends the credit balance amounts to our finance office after 180 days if the NPI number does not generate claim payments.

# Reading the Remittance Advice (RA)

RA Number: 8765432		Warrant/EFT #: 852741!		Warrant/EFT Date: 06/05/2014		Prepared Date: 06/06/2014		RA Date: 06/06/2014		Page 15				
Category: Denied		Billing Provider: 1122334455												
Client Name / Client ID / Med Record # / Patient Acct # / Original TCN/	TCN / Claim Type / RX Claim # / Inv # / Auth #	Line #	Rendering Provider / RX # / Auth office #	Service Date(s)	Svc Code or NDC / Mod / Rev & Class Code	Total Units or D/S	Billed Amount	Allowed Amount	Sales Tax	TPL Amount	Client Responsible Amount	Paid Amount	Remark Codes	Adjustment Reason Codes / NCPDP Rejection Codes
SMITH, JOHN D 147258369WA  100694KR 98164	201498798798798798 Dental Claim	1		05/07/2014- 05/07/2014	D0210	1.0000	\$44.53	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		119 = \$44.53
Document Total:			05/07/2014-05/07/2014			1.0000	\$44.53	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
SMITH, JOHN D 147258369WA  100329KS 91353	201496385274196385 Dental Claim	1		05/09/2014- 05/09/2014	D5212	1.0000	\$276.28	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		15 = \$276.28
Document Total:			05/09/2014-05/09/2014			1.0000	\$276.28	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		15
SMITH, JOHN D 147258369WA  100672AT 100453	201445612378945612 Dental Claim	1		05/06/2014- 05/06/2014	D9230	1.0000	\$20.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		119 = \$20.00
Document Total:			05/06/2014-05/06/2014			1.0000	\$20.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
Category Total:						16.0000	\$904.81	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		

# Reading the Remittance Advice (RA)

## ➤ EOB Codes

- ✓ The Adjustment Reason Codes; and
- ✓ The Remark Codes for denied claims & payment adjustments are located on the last page of the RA.

### Adjustment Reason Codes / NCPDP Rejection Codes

119 : Benefit maximum for this time period or occurrence has been reached.

15 : The authorization number is missing, invalid, or does not apply to the billed services or provider.

16 : Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

18 : Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)

35 : Lifetime benefit maximum has been reached.

96 : Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

### Remark Codes

N20 : Service not payable with other service rendered on the same date.

N329 : Missing/incomplete/invalid patient birth date.

N37 : Missing/incomplete/invalid tooth number/letter.

N39 : Procedure code is not compatible with tooth number/letter.

- ✓ The complete list of Federal codes can be located on <http://www.wpc-edl.com/reference/>

# Authorization

# Authorization

- 1 Complete Authorization Form 13-835
- 2 Submit Authorization Request to the Agency with Required Back-up
- 3 Check the Status of a Request
- 4 Send in Additional Documentation if Requested by the Agency

# Authorization

## ➤ Complete Authorization Form **13-835**

- a) To begin the authorization process providers need to complete HCA Form 13-835. ProviderOne can begin processing the authorization request once the Agency receives this form filled out correctly.
- b) Access the online authorization form 13-835 at  
<http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx>

Step by step instructions:

[ProviderOne Billing and Resource Guide](#)

Washington State Health Care Authority

### General Information for Authorization

Org	1. <input type="text"/>	Service Type	2. <input type="text"/>
<b>Client Information</b>			
Name	3. <input type="text"/>	Client ID	4. <input type="text"/>
Living Arrangements	5. <input type="text"/>	Reference Auth #	6. <input type="text"/>
<b>Provider Information</b>			
Requesting NPI #	7. <input type="text"/>	Requesting Fax #	8. <input type="text"/>
Billing NPI #	9. <input type="text"/>	Name	10. <input type="text"/>
Referring NPI #	11. <input type="text"/>	Referring Fax #	12. <input type="text"/>
Service Start Date:	13. <input type="text"/>		14. <input type="text"/>
<b>Service Request Information</b>			
Description of service being requested:		15. <input type="text"/>	16. <input type="text"/>
18. Serial/NEA or MEA #		19. <input type="text"/>	
20. Code Qualifier	21. National Code	22. Mod	23. # Units/Days Requested
24. \$ Amount Requested	25. Part # (DME Only)		26. Tooth or Quad #
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Medical Information</b>			
Diagnosis Code	27. <input type="text"/>	Diagnosis name	28. <input type="text"/>
Place of service	29. <input type="text"/>		
30. Comments: <input type="text"/>			

<http://www.hca.wa.gov/medicaid/forms/Pages/Index.aspx>

Please fax this form and any supporting documents to 1-866-668-1214.

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. HIPAA Compliance: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

HCA 13-835 (8/14)

# Directions for Authorization form 13-835

Instructions to fill out the General Information for Authorization form, HCA 13-835

FIELD	NAME	ACTION																																																																																																																								
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1	Org (Required)	Enter the Number that Matches the Program/Unit for the Request 501 – Dental 502 – Durable Medical Equipment (DME) 504 – Home Health 505 – Hospice 506 – Inpatient Hospital 508 – Medical 509 – Medical Nutrition 511 – Outpt Proc/Diag 513 – Physical Medicine & Rehabilitation (PM & R) 514 – Aging and Long-Term Support Administration (ALISA) 518 – LTAC 519 – Respiratory 521 – Maternity Support/Infant Case Management 524 – Concurrent Care 525 – ABA Services 526 – Complex Rehabilitation Technology (CRT) 527 – Chemical-Using Pregnant (CUP) Women Program																																																																																																																								
2	Service Type (Required)	Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "501 – Dental" for field #1, please select one of the following codes for this field: <table><tr><td>ASC</td><td>for ASC</td><td>OUTP</td><td>for Out-Patient</td></tr><tr><td>CWN</td><td>for Crowns</td><td>PSM</td><td>for Perio-Scaling/Maintenance</td></tr><tr><td>DEN</td><td>for Dentures</td><td>PTL</td><td>for Partial</td></tr><tr><td>DP</td><td>for Denture/Partial</td><td>RBS</td><td>for Rebases</td></tr><tr><td>ERSO</td><td>for ERSO-PA</td><td>RLNS</td><td>for Relines</td></tr><tr><td>EXT</td><td>for Extractions</td><td>MISC</td><td>for Miscellaneous</td></tr><tr><td>EXTD</td><td>for Extractions w/Dentures</td><td></td><td></td></tr><tr><td>IP</td><td>for In-Patient</td><td></td><td></td></tr><tr><td>ODC</td><td>for Orthodontic</td><td></td><td></td></tr></table> If you selected "502 – Durable Medical Equipment (DME)" for field #1, please select one of the following codes for this field: <table><tr><td>AA</td><td>for Ambulatory Aids</td><td>OS</td><td>for Orthopedic Shoes</td></tr><tr><td>BB</td><td>for Bath Bench</td><td>OTC</td><td>for Orthotics</td></tr><tr><td>BEM</td><td>for Bath Equipment (misc.)</td><td>OP</td><td>for Ostomy Products</td></tr><tr><td>BGS</td><td>for Bone Growth Stimulator</td><td>ODME</td><td>for Other DME</td></tr><tr><td>BP</td><td>for Breast Pump</td><td>OTRR</td><td>for Other Repairs</td></tr><tr><td>C</td><td>for Commode</td><td>PL</td><td>for Patient Lifts</td></tr><tr><td>CG</td><td>for Compression Garments</td><td>PWH</td><td>for Power Wheelchair - Home</td></tr><tr><td>CSC</td><td>for Commode/Shower Chair</td><td>PWNF</td><td>for Power Wheelchair – NF</td></tr><tr><td>DTS</td><td>for Diabetic Testing Supplies (See Pharmacy Billing - Instructions for POS Billing)</td><td>PWR</td><td>for Power Wheelchair Repair</td></tr><tr><td>ERSO</td><td>for ERSO-PA</td><td>PRS</td><td>for Prone Stenders</td></tr><tr><td>FSFS</td><td>for Floor Sitter/Feeder Seat</td><td>PROS</td><td>for Prosthetics</td></tr><tr><td>HB</td><td>for Hospital Beds</td><td>RE</td><td>for Room Equipment</td></tr><tr><td>HC</td><td>for Hospital Crib</td><td>SC</td><td>for Shower Chairs</td></tr><tr><td>IS</td><td>for Incontinent Supplies</td><td>SBS</td><td>for Specialty "Beds/Surfaces</td></tr><tr><td>MWH</td><td>for Manual Wheelchair - Home</td><td>SGD</td><td>for Speech Generating Devices</td></tr><tr><td>MWNF</td><td>for Manual Wheelchair – NF</td><td>SF</td><td>for Standing Frames</td></tr><tr><td>MWR</td><td>for Manual Wheelchair Repair</td><td>STND</td><td>for Stenders</td></tr><tr><td></td><td></td><td>TU</td><td>for TENS Units</td></tr><tr><td></td><td></td><td>US</td><td>for Urinary Supplies</td></tr><tr><td></td><td></td><td>WDOS</td><td>for VAC/Wound - decubiti supplies</td></tr><tr><td></td><td></td><td>MISC</td><td>for Miscellaneous</td></tr></table>	ASC	for ASC	OUTP	for Out-Patient	CWN	for Crowns	PSM	for Perio-Scaling/Maintenance	DEN	for Dentures	PTL	for Partial	DP	for Denture/Partial	RBS	for Rebases	ERSO	for ERSO-PA	RLNS	for Relines	EXT	for Extractions	MISC	for Miscellaneous	EXTD	for Extractions w/Dentures			IP	for In-Patient			ODC	for Orthodontic			AA	for Ambulatory Aids	OS	for Orthopedic Shoes	BB	for Bath Bench	OTC	for Orthotics	BEM	for Bath Equipment (misc.)	OP	for Ostomy Products	BGS	for Bone Growth Stimulator	ODME	for Other DME	BP	for Breast Pump	OTRR	for Other Repairs	C	for Commode	PL	for Patient Lifts	CG	for Compression Garments	PWH	for Power Wheelchair - Home	CSC	for Commode/Shower Chair	PWNF	for Power Wheelchair – NF	DTS	for Diabetic Testing Supplies (See Pharmacy Billing - Instructions for POS Billing)	PWR	for Power Wheelchair Repair	ERSO	for ERSO-PA	PRS	for Prone Stenders	FSFS	for Floor Sitter/Feeder Seat	PROS	for Prosthetics	HB	for Hospital Beds	RE	for Room Equipment	HC	for Hospital Crib	SC	for Shower Chairs	IS	for Incontinent Supplies	SBS	for Specialty "Beds/Surfaces	MWH	for Manual Wheelchair - Home	SGD	for Speech Generating Devices	MWNF	for Manual Wheelchair – NF	SF	for Standing Frames	MWR	for Manual Wheelchair Repair	STND	for Stenders			TU	for TENS Units			US	for Urinary Supplies			WDOS	for VAC/Wound - decubiti supplies			MISC	for Miscellaneous
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2	Service Type (Required) (Continued)	<p>If you selected "514 – Aging and Long-Term Support Administration (ALSA)" for field #1, please select one of the following codes for this field:</p> <p>PDN for Private Duty Nursing MISC for Miscellaneous</p> <p>If you selected "518 – LTAC" for field #1, please select one of the following codes for this field:</p> <p>ERSO for ERSO-PA LTAC for LTAC O for Other</p> <p>If you selected "519 – Respiratory" for field #1, please select one of the following codes for this field:</p> <p>CPAP for CPAP/BiPAP                      OXY for Oxygen ERSO for ERSO-PA                      SUP for Supplies NEB for Nebulizer                      VENT for Vent OXM for Oximeter                      O for Other</p> <p>If you selected "521 – Maternity Support/Infant Case Management (MSS)" for field #1, please select one of the following codes for this field:</p> <p>ICM for Infant Case Management PO for Post Pregnancy Only PPP for Prenatal/Post Pregnancy O for Other</p> <p>If you selected "524 – Concurrent Care" (for children on Hospice) for field #1, please select one of the following codes for this field:</p> <p>CC for Concurrent Care Services</p> <p>Enter the letter(s) in all CAPS that represent the service type you are requesting. If you selected "525 – ABA Services" for field #1, please select one of the following codes for this field:</p> <p>IH for In Home/Community/Office DAYP for Day Program</p> <p>If you selected "526 – Complex Rehabilitation Technology" (CRT) for field #1, please select one of the following codes for this field:</p> <p>ERSO for ERSO-PA                      PWH for Power Wheelchair - Home MWH for Manual Wheelchair - Home                      PWNF for Power Wheelchair - NF MWNF for Manual Wheelchair - NF                      PWR for Power Wheelchair Repairs MWR for Manual Wheelchair Repairs                      PWS for Power Wheelchair Supplies MWS for Manual Wheelchair Supplies</p> <p>If you selected "527 – Chemical-Using Pregnant (CUP) Women Program" for field #1, please select one of the following codes for this field:</p> <p>DX for Detox DM for Detox/Medical Stabilization MS for Medical Stabilization</p>

FIELD	NAME	ACTION
		<b>ALL FIELDS MUST BE TYPED.</b>
3	Name: (Required)	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: (Required)	<p>Enter the client ID - 9 numbers followed by WA.</p> <p>For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending):</p> <ul style="list-style-type: none"> <li>You will need to contact HCA at 1-800-562-3022 and the appropriate extension of the Authorization Unit.</li> <li>A reference PA will be built with a placeholder client ID.</li> <li>If the PA is approved – once the client ID is known – you will need to contact HCA either by fax or phone with the Client ID.</li> </ul> <p>The PA will be updated and you will be able to bill the services approved.</p>
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: (Required)	The 10 digit number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Billing NPI #: (Required)	The 10 digit number that has been assigned to the billing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: (Required).	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA or MEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA/MEA# to access the x-rays/pictures for this request.
20	Code Qualifier: (Required).	<p>Enter the letter corresponding to the code from below:</p> <p>T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code</p>
21	National Code: (Required).	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: (Units or \$ required).	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <a href="#">Medicaid Provider Guide</a> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: (Units or \$ required).	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <a href="#">Medicaid Provider Guide</a> and <a href="#">fee schedules</a> for assistance). Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00).
25	Part # (DME only): (Required for all requested codes).	Enter the manufacturer part # of the item requested.

# Directions for Authorization form 13-835

FIELD	NAME	ACTION																																																																
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26	Tooth or Quad#: (Required for dental requests)	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-32, A-T, AS-TS, and 51-82																																																																
27	Diagnosis Code	Enter appropriate diagnosis code for condition.																																																																
28	Diagnosis name	Short description of the diagnosis.																																																																
29	Place of Service	Enter the appropriate two digit place of service code. <b>Place of Service Code(s)</b>																																																																
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# Check Status of an Authorization Request

Online Services:	
<b>Claims</b>	<a href="#">Hide/Max</a>
<a href="#">Claim Inquiry</a>	
<a href="#">Claim Adjustment/Void</a>	
<a href="#">On-line Claims Entry</a>	
<a href="#">On-line Batch Claims Submission (837)</a>	
<a href="#">Resubmit Denied/Voided Claim</a>	
<a href="#">Retrieve Saved Claims</a>	
<a href="#">Manage Templates</a>	
<a href="#">Create Claims from Saved Templates</a>	
<a href="#">Manage Batch Claim Submission</a>	
<b>Client</b>	<a href="#">Hide/Max</a>
<a href="#">Client Limit Inquiry</a>	
<a href="#">Benefit Inquiry</a>	
<b>Payments</b>	<a href="#">Hide/Max</a>
<a href="#">View Payment</a>	
<a href="#">View Capitation Payment</a>	
<b>ProviderOne-Generated Invoices</b>	<a href="#">Hide/Max</a>
<a href="#">View Invoice</a>	
<a href="#">Validate Invoice</a>	
<b>Managed Care</b>	<a href="#">Hide/Max</a>
<a href="#">View Enrollment Roster</a>	
<a href="#">View ETRR</a>	
<b>Prior Authorization</b>	<a href="#">Hide/Max</a>
<a href="#">On-line Prior Authorization Submission</a>	
<a href="#">Prior Authorization Inquiry</a>	
<a href="#">Prior Authorization Adjustment</a>	

<a href="#">Close</a> <a href="#">Submit</a>	
PA Inquire: <input type="text"/>	
To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click 'Submit'.	
<ul style="list-style-type: none"><li>• Prior Authorization Number; or</li><li>• Provider NPI AND Client ID; or</li><li>• Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth</li></ul>	
For additional information, please contact our Customer Service Center (WA State DSHS Provider Relations) (800) 562-3022	
Prior Authorization Number:	<input type="text"/>
Provider NPI:	<input type="text"/>
Client ID:	<input type="text"/>
Client Last Name:	<input type="text"/>
Client First Name:	<input type="text"/>
Client Date of Birth:	<input type="text"/>

# Check Status of an Authorization Request

➤ Select **Provider Authorization Inquiry** from the provider home page.

✓ Search by one of the Options:

- Prior Authorization number; or
- Provider NPI and Client ID; or
- Provider NPI, Client Last & First Name, and the client birth date.

✓ The system may return the following status information:



Close Submit

PA Inquiry:

To submit a Prior Authorization Inquiry, complete one of the following criteria sets and click 'Submit'.

- Prior Authorization Number; or
- Provider NPI AND Client ID; or
- Provider NPI, Client Last Name, Client First Name, AND Client Date of Birth

For additional information, please contact our Customer Service Center (WA State DSHS Provider Relations) (800) 562-3022

Prior Authorization Number:


Provider NPI:

Client ID:

Client Last Name:

Client First Name:

Client Date of Birth:

PA Utilization:																	
Authorization #: 870000004 Client ID: 9999999VVA Service: Miscellaneous Request Date: 12/23/2010 Service Start Date: 1/1/2011 Requestor ID: 8888888897									Authorization Status: Approved  Client Name: Organization: PA - DENTAL Last Updated Date: 8/17/2011 Service End Date: 9/30/2011 Requestor Name: Place Holder PA Provider								
Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	08/17/2011	8888888897	D0120	K-Dental Claim					01/01/2011	09/30/2011	0	99999	0	1	0	0	Approved

# Check the Status of a Request

Close

PA Utilization:

Authorization #: 100000226  
 Client ID: 100149763WA  
 Service: Partial  
 Request Date: 5/9/2010  
 Service Start Date: 6/14/2010  
 Requestor ID: 1972676971

Authorization Status: Approved  
 Client Name:  
 Organization: PA - DENTAL  
 Last Updated Date: 6/14/2010  
 Service End Date: 6/14/2011  
 Requestor Name:

Line #	Modified Date	Servicing Provider ID	Code	Claim Type	Modifier1	ToothNum	ToothSurf	Quad	From Date	To Date	Request Amount	Request Units	Auth Amount	Auth Units	Used Amount	Used Units	Status
1	06/14/2010	1297174503	D8213	K-Dental Claim				01	06/14/2010	06/14/2010	0	1	0	1	0	0	Approved

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

Requested	This means the authorization has been requested and received.
In Review	This means your authorization is currently being reviewed.
Cancelled	This means the authorization request has been cancelled.
Pended	This means we have requested additional information in order to make a decision on the request.
Referred	This means the request has been forwarded to a second level reviewer.
Approved/Hold	This means the request has been approved, but additional information is necessary before the authorization will be released for billing.
Approved/Denied	This means the request has been partially approved and some services have been denied.
Rejected	This means the request was returned to you as incomplete.
Approved	This means the Department has approved your request.
Denied	This means the Department has denied your request.

The above example authorization request (number) is in approved status. Other possible status of the authorization request is listed in the table at the left.



# Submit Prior Authorization Request

**ProviderOne**

**PA Pend Forms Submission Cover Sheet**

Authorization Reference #   
(Please enter 9 digit numeric value.)



Instructions will not appear on the printed coversheet

**INSTRUCTIONS:**  
Click ENTER on your keyboard after typing the number in above.  
Please use the Print Cover Sheet Button Above to print ONLY.  
Use Only ADOBE Reader to generate this coversheet. Other readers will not generate the barcode correctly.

**DO NOT USE FOR PHARMACY RELATED AUTHORIZATION REQUESTS!**

**Privacy Statement:**  
This material in this facsimile is intended only for the use of the individual who it is addressed and may contain information that is confidential, privileged and exempt from disclosure under applicable law.

**HIPAA Compliance:**  
Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment to see insurance payment or to perform other specific health care operations.

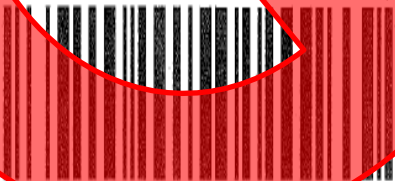
FAX to : 1-866-668-1214.

THE BAR CODE COVER SHEET SHOULD BE THE FIRST PAGE OF YOUR FAX WITH ALL SUPPORTING DOCUMENTATION BEHIND THE BAR CODE SHEET.

**ProviderOne**

**PA Pend Forms Submission Cover Sheet**

Authorization Reference #



Cover Sheets are located at :

[http://www.hca.wa.gov/medicaid/billing/pages/document\\_submission\\_cover\\_sheets.aspx](http://www.hca.wa.gov/medicaid/billing/pages/document_submission_cover_sheets.aspx)

# Spenddown

# What is a Spenddown?

- An expense or portion of an expense which has been determined by the Agency to be a client liability.
- Expenses which have been assigned to meet a client liability are not reimbursed by the Agency.
- Spenddown liability is deducted from any payment due the provider.
- See WAC 388-519 for complete details.



# Why does the client have a Spenddown?

- Applicant applies for the MN (Medically Needy Program).
  - ✓ Has income above MN limits for medical benefits.
  - ✓ Required to spend down excess income.
- Applicant spends down excess income by incurring medical bills.
- Client becomes eligible for Medicaid medical benefits once incurred medical bills equal the spenddown amount.

# How does a Provider know if a Client has a Spenddown Liability?

- Review the client eligibility screen in ProviderOne.
  - ✓ Benefit inquiry indicates "Pending Spenddown, No Medical."
  - ✓ Spenddown balance will be displayed.
- Ask the Client for a copy of their "**award**" letter.
  - ✓ Identifies the medical bills.
  - ✓ Indicates dollar amounts client must pay.
- Call the spenddown customer service center at 1-877-501-2233.

# How does a Provider know if a Client has a Spenddown Liability?

- The client benefit inquiry indicating **“Pending Spenddown – No Medical”** looks like this:

Client Eligibility Spans					
Service Type Code ▲ ▼	Insurance Type Code ▲ ▼	Benefit Service Package ▲ ▼	Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼	ACES Coverage Group ▲ ▼
30: Health Benefit Plan Coverage	MC: Medicaid	Pending Spenddown - No Medical	08/01/2011	12/31/2999	S99

# What is the Spenddown amount?

- The same eligibility check indicates the spenddown amount:

Spenddown Information

Base Period - Start: 08/01/2011 End: 01/31/2012

Total Spenddown ▲ ▼	Spenddown Liability ▲ ▼	Remaining Spenddown ▲ ▼	EMER Liability ▲ ▼	Remaining EMER ▲ ▼	Spenddown Status ▲ ▼	Update Date ▲ ▼	Spenddown Start ▲ ▼
2022.00	2022.00	2022.00	0.00	0.00	Pending	08/09/2011	08/01/2011

- Contact the spenddown customer service center at 1-877-501-2233

# When does a provider report the Spenddown amount on a claim?

- All providers must verify if the client has a spenddown if:
  - ✓ The client is on the LCP-MNP program.
  - ✓ The clients ACES Coverage Group Code ends with **"99"**.

Eligibility Start Date ▲ ▼	Eligibility End Date ▲ ▼	ACES Coverage Group ▲ ▼
08/01/2011	12/31/2999	S99

- ✓ The claim DOS is the same as the client eligibility begin date.
- ✓ Call the spenddown customer service center at 1-877-501-2233.

# When does a provider report the Spenddown amount on a claim?

- The agency checks the eligibility system (ACES) to see if the claim applies to the spenddown.
  - ✓ If claim applies and no spenddown is reported then the claim is denied.
  - ✓ If claim applies, spenddown must be reported accurately or the claim is denied.
  - ✓ If claim applies, spenddown is subtracted from service allowable and provider may be paid any difference.

# What if the client has Medicare Primary and a Spenddown?

## ➤ QMB client eligibility

- ✓ May have two active coverage segments at the same time.
  - The first segment is their QMB with the dates of coverage.
  - Second segment may be the “**Pending Spenddown**” with overlapping dates with the QMB segment.
- ✓ Bill Medicare, then Medicaid as a crossover:
  - Medicaid may pay the crossover (depends on the Medicare paid amount).
  - Cannot bill the client for these balance amounts.
  - No spenddown amount to report on these claims.
- ✓ Services not covered by Medicare are used to satisfy the spenddown **NOT** the crossover claim.

# How does a provider report the Spenddown amount on a claim?

## ➤ CMS-1500

- ✓ Electronic batch claims (837P)
  - HIPAA 5010, Loop 2300 in the
  - Patient Amount Paid segment
    - Use value qualifier F5 in AMT01
    - Then enter the \$\$ amount in AMT02
- ✓ Paper claim enter the spenddown
  - In field 19, comments
  - Enter **Spenddown**
  - Then enter the \$\$ amount



# When can a provider bill the client for their Spenddown amount?

- If your claim is on the award letter as part of the incurred expenses to meet the spenddown.
  - ✓ No award letter? Call 1-877-501-2233
  
- No waiver form is required to bill the client for their spenddown liability.
  - ✓ Can bill the client only for the spenddown liability amount not the balance of a claim if the Agency makes a payment.

# When can a provider bill the Client?

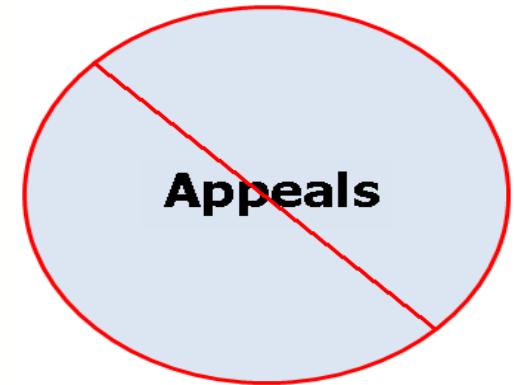
- Provider billed Medicaid for the services and the claim is denied as “Client pending spenddown.”
- Client then satisfies spenddown and becomes Medicaid eligible.
- Provider is to check eligibility again before billing the client:
  - ✓ If client is now eligible, bill Medicaid.
  - ✓ If client is eligible and provider has billed client, they need to stop and bill Medicaid.
  - ✓ If the client is eligible and a claim should have been billed to Medicaid, do not send the client to collections but bill Medicaid.

# When can a provider bill the Client?

- Client that satisfies spenddown and becomes Medicaid eligible, that eligibility is called retro eligibility.
- Per retro eligibility rules if client has paid anything, refund client and bill Medicaid.
- All billing the client rules apply.
- See the billing the client WAC 182-502-0160 for complete detailed information.

# Claim Appeals

# Claim Appeals



- We don't have an "appeal process" for denied claims.
- Fix the claim error causing claim denial and resubmit the claim.
- If you think the claim(s) were denied in error submit a work ticket online at <https://fortress.wa.gov/hca/p1contactus/>
- Work tickets average 25 days to process and complex tickets can take longer.

# Billing a Client

# LEARNING OBJECTIVES

As a result of this webinar providers will:

- Understand when a provider can and cannot bill a client for healthcare services.
- Know when a provider can bill a client without HCA form 13-879, titled *Agreement to Pay for Healthcare Services*.
- Know how to complete HCA form 13-879, and know when it is and is not required.

These rules apply only to providers who have completed a Core Provider Agreement (CPA) or are contracted with an Agency-contracted Managed Care Organization (MCO).

# WHY THIS IS IMPORTANT

Following these rules may protect a provider from:

- Termination of CPA or MCO contracts
- Being excluded from participation in federal contracting, including Medicare
- Audit
- Fraud Charges and Prosecution



# BACKGROUND

Effective for dates of service on and after May 27, 2010, Health Care Authority implemented revisions to Washington Administrative Code (WAC) 182-502-0160, *Billing a Client*, allowing providers, in limited circumstances, to bill fee-for-service or managed care clients for covered healthcare services, and allowing fee-for-service or managed care clients the option to self-pay for covered healthcare services.

The full text of WAC 182-502-0160 can be found at <http://apps.leg.wa.gov/wac/default.aspx?cite=182-502>.

# PROVIDER RESPONSIBILITIES

- You must verify whether the client is eligible to receive medical assistance services on the date the services are provided.
- You must verify whether the client is enrolled with an Agency-contracted managed care organization (MCO).
- You must know the limitations of the services within the client's benefits package (see WAC 182-501-0050 (4)(a) and 182-501-0065) and inform the client of those limitations.

# PROVIDER RESPONSIBILITIES

- Exhaust all applicable Agency or Agency-contracted MCO processes necessary to obtain authorization for a requested service.
- Ensure that translation or interpretation is provided to clients with limited English proficiency (LEP) who agree to be billed for services.
- Retain all documentation which demonstrates client and provider compliance with WAC, including any written and/or verbal agreements to pay for services, including your practice's own financial responsibility form.

# DEFINITIONS

**Healthcare Service Categories:** The groupings of healthcare services listed in the table in WAC 182-501-0060. Healthcare service categories are included or excluded depending on the client's benefits package.

**Benefits Package:** The set of healthcare service categories included in a client's eligibility program.

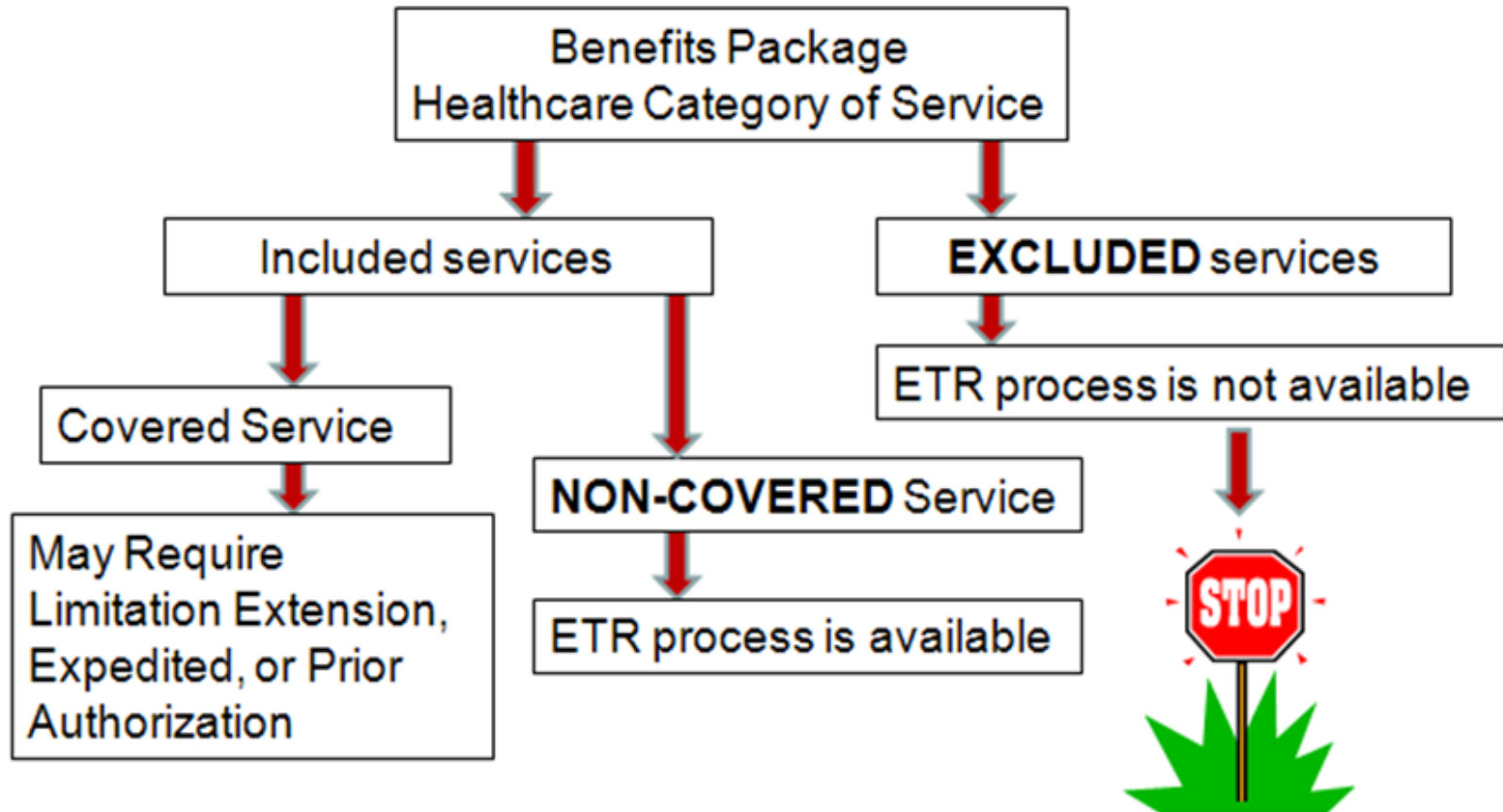
**Excluded Services:** A set of services that we do not include in the client's benefits package. There is no Exception to Rule (ETR) process available for these services.

# DEFINITIONS

**Covered service:** A healthcare service contained within a “service category” that is included in a medical assistance benefits package described in WAC 182-501-0060.

**Non-covered service:** A specific healthcare service contained within a service category that is included in a medical assistance benefits package, for which the Agency does not pay without an approved Exception to Rule (see WAC 182-501-0160). A **non-covered** service is not the same as an **excluded** service (see WAC 182-501-0060). Non-covered services are identified in WAC 182-501-0070 and in specific healthcare program rules.

# NON-COVERED VS. EXCLUDED



# NON-COVERED VS. EXCLUDED

Non-Covered	Excluded for Adults* (no funding for these services)
<p>Cosmetic surgery</p> <ul style="list-style-type: none"> <li>Physician services are covered, however cosmetic surgery is not covered under the client's benefits package.</li> </ul>	<p>Adult Vision Hardware</p>
<p>Hairpieces or wigs</p> <ul style="list-style-type: none"> <li>DME services are covered, however wigs are not covered under the DME benefits package.</li> </ul>	<p>Adult Hearing Hardware</p>
<p>Upright MRI</p> <ul style="list-style-type: none"> <li>Diagnostic procedures are covered, but this specific procedure is not covered after a health technology review of its efficacy.</li> </ul>	<p>* 21 years of age and older</p>
<p><b>ETR CAN BE REQUESTED</b></p>	<p><b>NO ETR PROCESS AVAILABLE</b></p>

## WHEN FORM 13-879 IS **NOT** REQUIRED

- The client, the client's legal guardian, or the client's legal representative was reimbursed for the service directly by a third party, or refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third party insurance carrier for the service.
- The client represented him or herself as a private pay client, with no medical assistance coverage (FFS or MCO) while currently eligible for and receiving benefits under Washington Apple Health (Medicaid).



## WHEN FORM 13-879 IS **NOT REQUIRED**

- The bill counts toward the financial obligation of the client or applicant [such as spenddown liability, client participation (as described in WAC 182-513-1380), emergency medical expense requirement, deductible, or copayment required by the Agency].
- The client is under the Agency's or an Agency-contracted MCO's Patient Review & Coordination (PRC) program (WAC 182-501-0135) and receives nonemergency services from providers or healthcare facilities other than those to whom the client is assigned or referred under the PRC program.

## WHEN FORM 13-879 IS **NOT REQUIRED**

- The services were non-covered ambulance services [see WAC 182-546-0250(2)].
- The services were provided to a Take Charge – Family Planning Only (TCFPO) client, and the services are not within the scope of the client's benefits package.
- An Agency-contracted MCO enrollee chooses to receive nonemergency services from providers outside of the MCO's network without authorization from the MCO.

## WHEN FORM 13-879 IS **NOT REQUIRED**

- A provider can bill an adult client for **excluded** services, i.e., vision hardware or hearing devices
- Please discuss with the client if the service they are requesting is no longer paid for by the Agency so they can make an informed decision as to what costs they may incur

## WHEN FORM 13-879 **MUST BE USED**

- If the service is not covered, the provider must inform the client of his or her right to have the provider request an ETR, and the client chooses not to have the provider request an ETR.
- The service is not covered by the Agency, the provider requests an ETR and the ETR process is exhausted, and the service is denied.

## WHEN FORM 13-879 **MUST BE USED**

- The service is covered only with prior authorization; all the requirements for obtaining authorization were completed but the authorization was denied; the client completes the administrative hearings process or foregoes any part of it; and the service remains denied by the Agency as not medically necessary.
- The service is covered by the Agency without prior authorization; the service is provided based on the client's personal preference which the Agency does not pay for; and the client completes the administrative hearings process or chooses to forego any part of it.

# WHEN A CLIENT CAN **NEVER** BE BILLED

A client can never be billed, with or without Form 13-879, in the following situations:

- Services for which the provider did not correctly bill the Agency or MCO.
- If the Agency or MCO returns or denies a claim for correction and resubmission, the client cannot be billed.

For directions on billing fee-for-service, see the *ProviderOne Billing & Resource Guide*. For directions on how to bill a client's MCO, please contact the plan directly.

## WHEN A CLIENT **CANNOT BE BILLED**

- Services for which the Agency or MCO denied the authorization because the process was placed on hold pending receipt of requested information, and the requested information was never received by the Agency (WAC 182-501-0165(7)(c)(i)). This includes authorization requests that are returned due to missing required information (“rejected” status).
- The cost difference between an authorized service or item and an "upgraded" service or item preferred by the client (*e.g.*, a wheelchair with more features, or brand name drugs versus generic drugs).

## WHEN A CLIENT **CANNOT BE BILLED**

- Copying, printing, or otherwise transferring healthcare information, as the term healthcare information is defined in Chapter 70.02 RCW, to another healthcare provider, which includes, but is not limited to medical/dental charts, radiological or imaging films, and laboratory or other diagnostic test results
- Missed, cancelled, or late appointments
- Shipping and/or postage charges



## WHEN A CLIENT **CANNOT BE BILLED**

- Services for which the provider has not received payment from the Agency or the client's MCO because the provider did not complete all requirements necessary to obtain payment (*e.g.*, billing using a diagnosis code which is not a primary ICD-9 diagnosis).
- “Boutique”, “concierge”, or other enhanced services (*e.g.*, newsletters, 24-hour access to provider, health seminars) as a condition for access to care.

Providers are prohibited from “balance billing” a client, *i.e.*, charging the difference between usual, customary rates and the Agency’s payment.

# FORM 13-879 (FRONT)



## Agreement to Pay for Healthcare Services

WAC 182-502-0160 ("Billing a Client")

This is an agreement between a "client" and a "provider," as defined below. The client agrees to pay the provider for healthcare service(s) that the Health Care Authority (HCA) will not pay. Both parties must sign this Agreement. For the purposes of this Agreement, "services" include but are not limited to healthcare treatment, equipment, supplies, and medications.

**Client** - A recipient of Medicaid or other healthcare benefits through the HCA or a managed care organization (MCO) that contracts with the HCA.

**Provider** - An institution, agency, business, or person that provides healthcare services to HCA clients and has a signed agreement with the HCA or authorization from an MCO.

This Agreement and WAC 182-502-0160 apply to billing a client for covered and noncovered services as described in WAC 182-501-0050 through WAC 182-501-0070. Providers may not bill any HCA client (including those enrolled with an MCO that contracts with the HCA) for services which the HCA or an MCO that contracts with the HCA may have paid until the provider has completed all requirements for obtaining authorization.

CLIENT'S PRINTED NAME	CLIENT'S ID NUMBER
PROVIDER'S PRINTED NAME	PROVIDER NUMBER

### Directions:

- Both the provider and the client must fully complete this form **before** an HCA client receives any service for which this Agreement is required.
- You must complete this form no more than 90 calendar days before the date of the service. If the service is not provided within 90 calendar days, the provider and client must complete and sign a new form.
- The provider and the client must complete this form only **after** they exhaust all applicable HCA or HCA-contracted MCO processes which are necessary to obtain authorization for the requested service(s). These may include the exception to rule (ETR) process for noncovered services as described in WAC 182-501-0160 or the administrative hearing process, if the client chooses to pursue these processes.
- Limited English proficient (LEP) clients must be able to understand this form in their primary language. This may include a translated form or interpretation of the form. If the form is interpreted for the client, the interpreter must also sign and date the form. Both the client and the provider must sign a translated form.

**Fully complete the table on back of this form. If needed, attach another sheet for additional services. The client, provider, and interpreter (if applicable) must sign and date each additional page.**

### Important Note from HCA:

- This agreement is void and unenforceable if the provider fails to comply with the requirements of this form and WAC 182-502-0160 or does not satisfy HCA conditions of payment as described in applicable Washington Administrative Code (WAC) and Billing Instructions. The provider must reimburse the client for the full amount paid by the client.
- See WAC 182-502-0160(9) for a list of services that cannot be billed to a client, regardless of a written agreement.
- Keep the original agreement in the client's medical record for 6 years from the date this agreement is signed. Give a copy of this completed, signed agreement to the client.
- Providers are responsible for ensuring that translation or interpretation of this form and its content is provided to LEP clients. Translated forms are available at <http://hrsa.dshs.wa.gov/mpforms.shtml>.

AGREEMENT TO PAY FOR HEALTHCARE SERVICES  
HCA 13-879 (8/12)

Page 1 of 2

# FORM 13-879 (BACK)

SPECIFIC SERVICE(S) OR ITEM(S) TO BE PROVIDED AND ANTICIPATED DATE OF SERVICE	CPT/CDT/ HCPC CODE (BILLING CODE)	AMOUNT TO BE PAID BY CLIENT	REASON WHY THE CLIENT IS AGREEING TO BE BILLED (CHECK THE ONE THAT APPLIES FOR EACH SERVICE)	COVERED TREATMENT ALTERNATIVES OFFERED BUT NOT CHOSEN BY CLIENT	DATE(S) ETR/NFJ REQUESTED/DENIED OR WAIVED, OR PRIOR AUTHORIZATION (PA) REQUESTED/DENIED, IF APPLICABLE	
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		ETR REQUESTED OR WAIVED	ETR DENIAL (ATTACH HCA NOTICE)
			<input type="checkbox"/> Noncovered service <input type="checkbox"/> Noncovered service, ETR waived <input type="checkbox"/> Non-formulary drug, NFJ waived <input type="checkbox"/> Covered but denied as not medically necessary <input type="checkbox"/> Covered, but specific type not paid for <input type="checkbox"/> Order, prescribed, or referred by non-enrolled licensed health care professional		PA REQUEST	PA DENIAL (ATTACH HCA NOTICE)

- I understand that HCA or an MCO that contracts with HCA will not pay for the specific service(s) being requested for one of the following reasons, as indicated in the above table: 1) HCA does not cover the service(s); 2) the service(s) was denied as not medically necessary for me, or 3) the service(s) is covered but the type I requested is not.
- I understand that I can, but may choose not to: 1) ask for an Exception to Rule (ETR) after an HCA or HCA-contracted MCO denial of a request for a noncovered service; 2) submit a Non-Formulary Justification (NFJ) with the help of my prescriber for a non-formulary medication; or 3) ask for a hearing to appeal an HCA or HCA-contracted MCO denial of a requested service.
- I have been fully informed by this provider of all available medically appropriate treatment, including services that may be paid for by the HCA or an HCA-contracted MCO, and I still choose to get the specified service(s) above.
- I understand that HCA does not cover services ordered by, prescribed by, or are a result of a referral from a healthcare provider who is not contracted with HCA as described in Chapter 182-502 WAC.
- I agree to pay the provider directly for the specific service(s) listed above.*
- I understand the purpose of this form is to allow me to pay for and receive service(s) for which HCA or an HCA-contracted MCO will not pay. This provider answered all my questions to my satisfaction and has given me a completed copy of this form.
- I understand that I can call HCA at 1-800-562-3022 to receive additional information about my rights or services covered by HCA under fee-for-service or managed care.

<b>I AFFIRM: I understand and agree with this form's content, including the bullet points above.</b>	CLIENT'S OR CLIENT'S LEGAL REPRESENTATIVE'S SIGNATURE	DATE
<b>I AFFIRM: I have complied with all responsibilities and requirements as specified in WAC 182-502-0160.</b>	PROVIDER OF SERVICE(S) SIGNATURE	DATE
<b>I AFFIRM: I have accurately interpreted this form to the best of my ability for the client signing above.</b>	INTERPRETER'S PRINTED NAME AND SIGNATURE	DATE

## NOTES ON FORM 13-879

- The form must be completed no more than 90 days before the services are provided.
- Keep the original agreement in the client's medical record for six years from the date it is signed.
- A copy of this agreement must be given to the client.
- This form is available in eight different languages; use the appropriate version for non-English speakers (contact the Agency for languages not listed).
- Use an interpreter, when necessary, to ensure client understands all his or her options and is able to make an informed decision.

# SCENARIOS

A new client comes in for an appointment and documents she has no insurance when completing her registration. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

# SCENARIOS

A new client comes in for an appointment and documents she has no insurance when completing her registration. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

A client who represents herself as a self-pay patient can be billed without Form 13-879. Keep documentation of this lack of coverage in your records and give a copy to the client.

# SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

# SCENARIOS

A provider's claim is denied by the Agency for missing or invalid taxonomy. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) **Cannot be billed for this service**

Clients cannot be billed for denied claims that need to be corrected and resubmitted to the Agency.



# SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Package goes to see a physical therapist, but physical therapy is excluded from the LCP-MNP benefits package. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

# SCENARIOS

An adult client with the Limited Casualty Program – Medically Needy Program (LCP-MNP) Benefits Package goes to see a physical therapist, but physical therapy is excluded from the LCP-MNP benefits package. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

Clients can be billed for excluded services without completing Form 13-879.

# SCENARIOS

A new client comes in for an appointment, states she has Medicaid, but does not have her Client Services card available. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

# SCENARIOS

A new client comes in for an appointment, states she has Medicaid, but does not have her Client Services card available. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) **Cannot be billed for this service**

There are many ways to check eligibility other than using the ProviderOne Client Services Card. Please visit the ProviderOne Billing and Resource Guide for more information on checking eligibility.

# SCENARIOS

An adult client goes in for a routine physical with no medical concerns. The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

# SCENARIOS

An adult client goes in for routine physical with no medical concerns (which the Agency does not cover). The client:

- a) Can be billed without HCA form 13-879
- b) Can be billed with HCA form 13-879
- c) Cannot be billed for this service

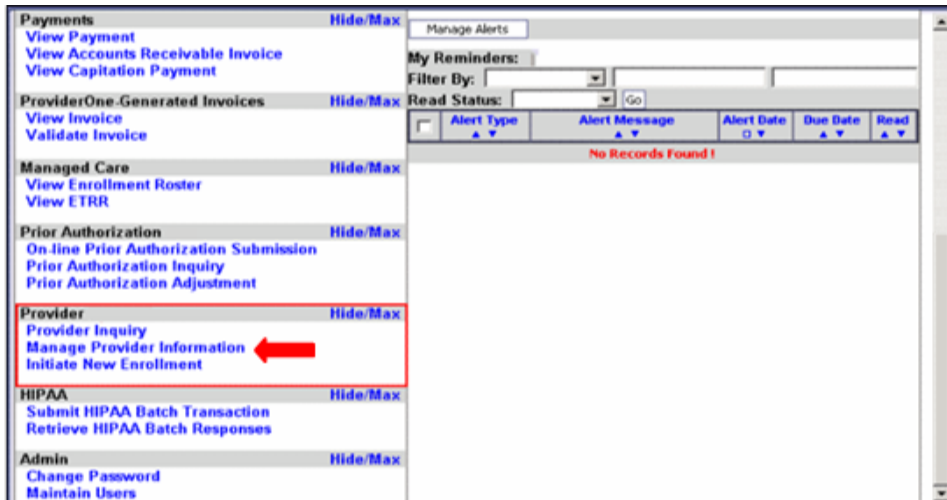
While some services during the exam may be covered, the exam itself may be non-covered if billed as a routine physical. A client can be billed for these services after completing form 13-879.

# Provider File Maintenance

# Provider File Maintenance

## ➤ Modifying Provider File Information

- ✓ Log into ProviderOne with the **Provider File Maintenance** or **Supers User** profile.
- ✓ Click on the **Manage Provider Information** hyperlink



Provider Types include:

- ✓ Individual
- ✓ Group
- ✓ Tribal
- ✓ Facilities (FAOI)
- ✓ Servicing

- ✓ Go to web page <http://hrsa.dshs.wa.gov/provider/provideronemanuals.shtml> for the different of provider file update modification manuals.



# Provider File Maintenance

## ➤ Modifying Provider File Information

- ✓ The Business Process Wizard contains the steps for modification. Click on the step hyperlink to modify.

View/Update Provider Data - Group Practice:

**Business Process Wizard** - Provider Data Modification (Group Practice). In order to finalize submission of your requested changes, you must c

<input type="checkbox"/>	Step	Required	Last Modification Date	Last Review Date	Status
<input type="checkbox"/>	<a href="#">Step 1: Basic Information</a>	Required	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 2: Locations</a>	Required	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 3: Specializations</a>	Required	06/15/2010	07/22/2010	Complete
<input type="checkbox"/>	<a href="#">Step 4: Ownership Details</a>	Required	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 5: Licenses and Certifications</a>	Required	06/15/2010	07/22/2010	Complete
<input type="checkbox"/>	<a href="#">Step 6: Training and Education</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 7: Identifiers</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 8: Contract Details</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 9: Federal Tax Details</a>	Required	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 10: Invoice Details</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 11: EDI Submission Method</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 12: EDI Billing Software Details</a>	Optional	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 13: EDI Submitter Details</a>	Required	01/19/2011	01/19/2011	Complete
<input type="checkbox"/>	<a href="#">Step 14: EDI Contact Information</a>	Optional	05/10/2010	05/10/2010	Complete
<input type="checkbox"/>	<a href="#">Step 15: Servicing Provider Information</a>	Required	08/31/2011	09/06/2011	Complete
<input type="checkbox"/>	<a href="#">Step 16: Payment Details</a>	Required	09/30/2009	09/30/2009	Complete
<input type="checkbox"/>	<a href="#">Step 17: Submit Modification for Review</a>	Required	09/30/2009	09/30/2009	Complete

# Provider File Maintenance

## ➤ Step 3: Specializations (Taxonomy Codes)

Close Add Update

Note: Provider Type and Specialty/Subspecialty are your Taxonomy Codes.

Specialty/Subspecialty List:

Filter By :  And

Status: Active

<input type="checkbox"/>	Provider Type ▲ ▼	Specialty/Subspecialty ▲ ▼	Administration ▲ ▼	Start Date ▲ ▼	End Date ▲ ▼	Operational Status ▲ ▼	Status ▲ ▼
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	HRSA	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/V0102-Vascular Neurology	MHD	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0012-Sleep Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/S0010-Sports Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	MHD	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P2900-Pain Medicine	HRSA	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	HRSA	05/01/1998	12/31/2999	Active	Approved
<input type="checkbox"/>	20-Allopathic & Osteopathic Physicians	84-Psychiatry & Neurology/P0805-Geriatric Psychiatry	MHD	05/01/1998	12/31/2999	Active	Approved

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- ✓ The first specialization taxonomy code is 20-84-V0102 then add a "X" to all or (2084V0102X).

# Provider File Maintenance

## ➤ Step 11:EDI Submission Method

✓ How are you going to bill us?

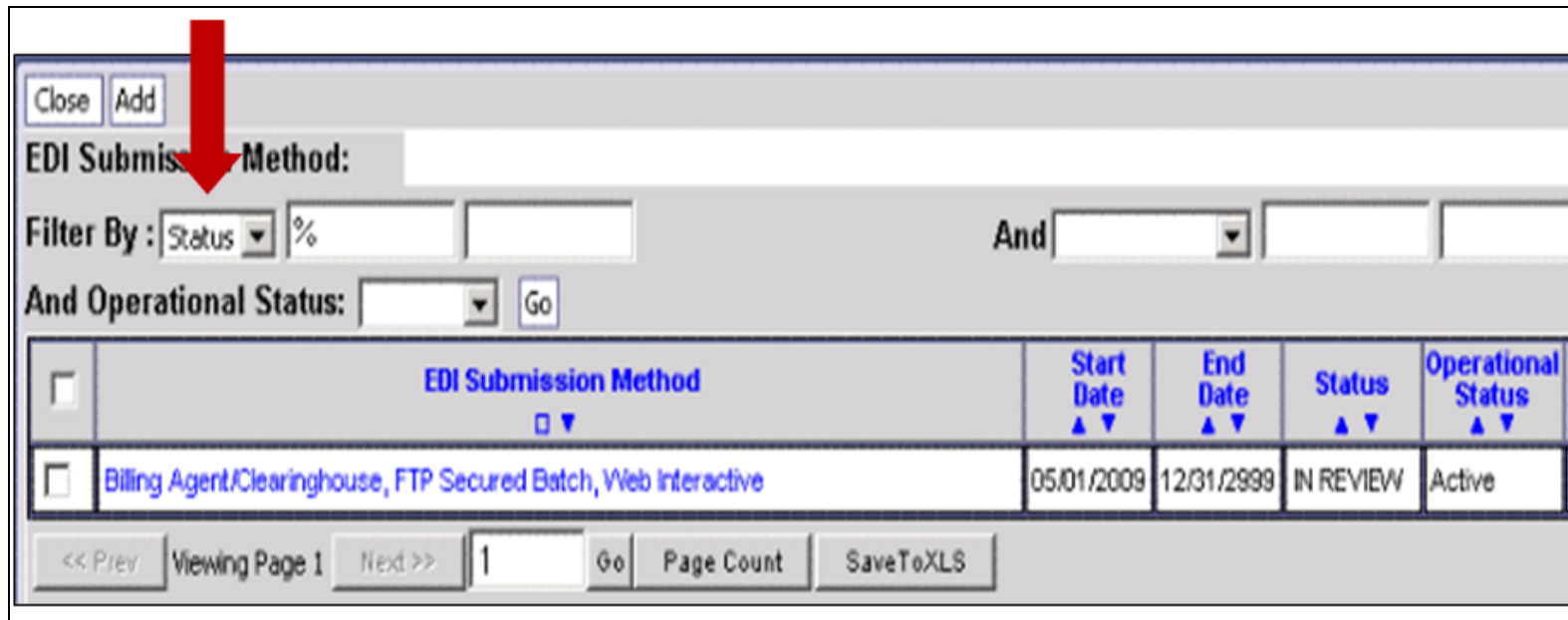
The screenshot shows a web browser window titled "EDI Submission Details - Windows Internet Explorer". The address bar shows "ProviderOne Id/NPI : 2857403 / 5522336671" and "Name: Mario Health Center". The main content area is titled "EDI Submission Details:" and includes a note: "You may check multiple Modes of Submission. NPI is required for all selections." Below this, a red warning states: "If Web Batch and/or FTP Secured Batch are selected, you must complete and mail a new ProviderOne Trading Partner Agreement." The form has two sections: "Mode of Submission:" with four checkboxes (Web Batch, Billing Agent/Clearinghouse, FTP Secured Batch, Web Interactive) and "Status:" with a value of "In Review". A table lists submission methods and their uses. At the bottom, there are two explanatory bullet points and "OK" and "Cancel" buttons.

Method	When to Use
Web Batch	For upload/download of files in ProviderOne
Billing Agent/Clearinghouse	For providers who use a 3rd party to bill
FTP Batch	For submitting files via an SFTP site
Web Interactive	For entering (keying) claims directly into ProviderOne

- Your EDI submission method is "Web Batch" if you currently upload and download batch files using WaMedWeb. This method is often used by providers who submit their own HIPAA batch transactions. It allows a maximum file size of 50MB.
- Your EDI submission method is "FTP Secured Batch" if you submit and retrieve batches at a secure web folder assigned to you by DSHS. This method was designed with clearinghouses and billing agents in mind. It allows a maximum file size of 100 MB.

# Provider File Maintenance

- Step 11:EDI Submission Method
  - ✓ Filter By: Status then add % and click



The screenshot shows a web application interface for "Provider File Maintenance". At the top, there are "Close" and "Add" buttons. Below them is a section for "EDI Submission Method:" with a text input field. A red arrow points to the "Filter By:" dropdown menu, which is currently set to "Status". To the right of the dropdown is a percentage input field and an "And" dropdown menu. Below this is an "And Operational Status:" dropdown menu and a "Go" button. The main part of the interface is a table with the following columns: "EDI Submission Method", "Start Date", "End Date", "Status", and "Operational Status". The table contains one row with the following data: "Billing Agent/Clearinghouse, FTP Secured Batch, Web interactive", "05/01/2009", "12/31/2999", "IN REVIEW", and "Active". At the bottom, there are navigation buttons: "<< Prev", "Viewing Page 1", "Next >>", "1", "Go", "Page Count", and "SaveToXLS".

EDI Submission Method	Start Date	End Date	Status	Operational Status
Billing Agent/Clearinghouse, FTP Secured Batch, Web interactive	05/01/2009	12/31/2999	IN REVIEW	Active

# Provider File Maintenance

## ➤ Step 13:EDI Submitter Details.

**Add Submitter - Windows Internet Explorer**

ProviderOne Id/NPI : 2857403 / 5522336671      Name: Mario Health Center

**Associate Billing Agent/Clearinghouse:**

Billing Agent/Clearinghouse ProviderOne Id:  \*

Start Date:  \*      End Date:

Status: In Review

**Note:** In the "Authorized Transaction Responses" section, please select 'yes' for any outbound HIPAA transactions that your clearinghouse acquires on your behalf.

**Authorized Transaction Responses:**

Transaction Response	Authorized	Start Date	End Date
271-Eligibility Response	No	<input type="text"/>	<input type="text"/>
277-Claim Status Response	No	<input type="text"/>	<input type="text"/>
277U-Unsolicited Claims Status Response	No	<input type="text"/>	<input type="text"/>
278-Prior Authorization Response	No	<input type="text"/>	<input type="text"/>
820-Premium Payment	No	<input type="text"/>	<input type="text"/>
834-Benefit Enrollment	No	<input type="text"/>	<input type="text"/>
835-Healthcare Claim Payment Advice	No	<input type="text"/>	<input type="text"/>

<< Prev    Viewing Page 1    Next >>    1    Go    Page Count    Save To XLS

OK    Cancel

<http://www.hca.wa.gov/medicaid/hipaa/pages/index.aspx>

# Provider File Maintenance

## ➤ Step 15: Servicing Provider Information

Welcome Jones, John . You have logged-in with EXT Provider File Maintenance profile. Links: --Select--

Path: Provider Portal/ Group Practice Modification  
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Close Add

Servicing Provider List:

Filter By :  And

And Operational Status : Active

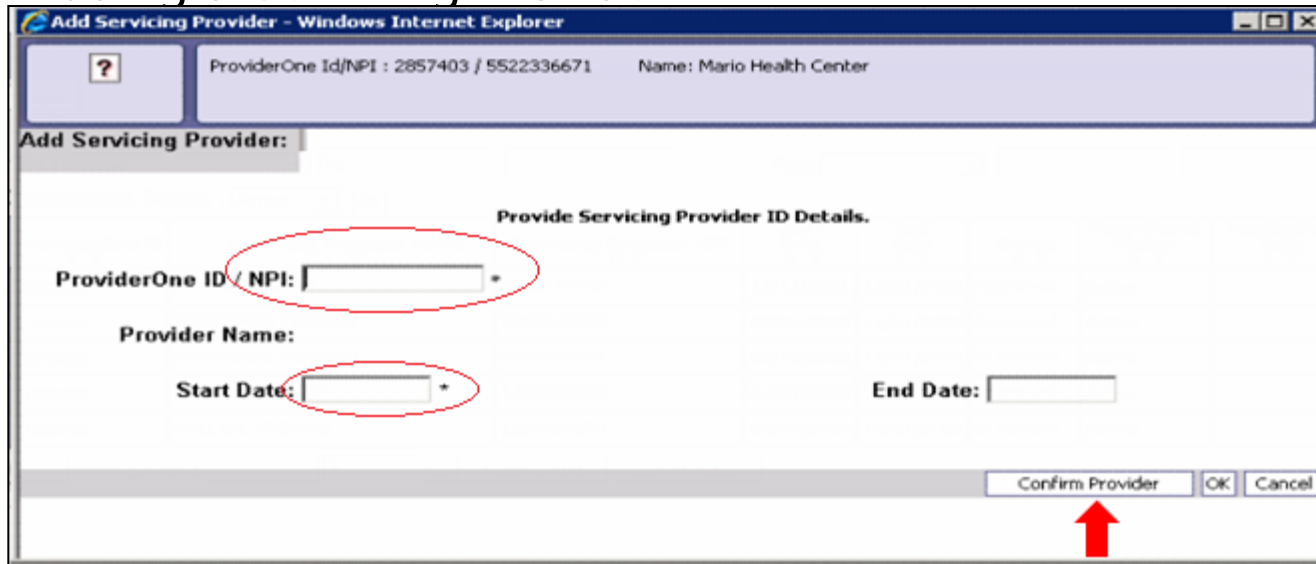
<input type="checkbox"/>	ProviderOne ID ▲▼	Servicing Provider Name ▲▼	Servicing Provider NPI □▼	Start Date ▲▼	End Date ▲▼	Status ▲▼	Operational Status ▲▼	Inactivation Date ▲▼
<input type="checkbox"/>	3050186	MARIO, ROBERT	5522447783	12/11/2001	12/31/2999	Approved	Active	
<input type="checkbox"/>	2370695	SOENSON, HERMAN	3334445558	07/01/2008	12/31/2999	Approved	Active	
<input type="checkbox"/>	1000092	GOLDEN, MICHAEL	1234567890	07/01/2008	12/31/2999	Approved	Active	

<< Prev Viewing Page 1 Next >> 1 Go Page Count SaveToXLS

# Provider File Maintenance

## ➤ Step 15: Servicing Provider Information

### ✓ Adding a Servicing Provider



The screenshot shows a web browser window titled "Add Servicing Provider - Windows Internet Explorer". The address bar displays "ProviderOne Id/NPI : 2857403 / 5522336671" and "Name : Mario Health Center". The main content area is titled "Add Servicing Provider:" and contains the instruction "Provide Servicing Provider ID Details." Below this, there are three input fields: "ProviderOne ID / NPI:" (circled in red), "Provider Name:" (empty), and "Start Date:" (circled in red). To the right of the "Start Date:" field is an "End Date:" field. At the bottom right, there are three buttons: "Confirm Provider", "OK", and "Cancel". A red arrow points to the "Confirm Provider" button.

✓ Enter the providers NPI number and start date at your clinic

✓ Click on the Confirm Provider button

# Provider File Maintenance

## ➤ Step 15: Servicing Provider Information

- ✓ Ending a provider association

The screenshot displays a web application interface for 'EXT Provider File Maintenance'. At the top, a welcome message reads 'Welcome Jones, John . You have logged-in with EXT Provider File Maintenance profile.' and a 'Links: --Select--' dropdown is visible. Below this, a breadcrumb path is shown: 'Path: Provider Portal/ Group Practice Modification'. The current provider information is listed as 'ProviderOne Id/NPI : 2857403 / 5522336671' and 'Name: Mario Health Center'. A toolbar contains 'Close' and 'Save' buttons. The main section is titled 'Manage Servicing Provider:' and contains the following fields: 'ProviderOne ID / NPI: 2370695', 'Provider Name: SORENSON, HERMAN', 'Status: Approved', 'Start Date: 07/01/2008 \*', and 'End Date: 12/31/2999'.

Welcome Jones, John . You have logged-in with EXT Provider File Maintenance profile. Links: --Select--

Path: Provider Portal/ Group Practice Modification  
ProviderOne Id/NPI : 2857403 / 5522336671 Name: Mario Health Center

Close Save

**Manage Servicing Provider:**

ProviderOne ID / NPI: 2370695

Provider Name: SORENSON, HERMAN

Status: Approved

Start Date: 07/01/2008 \* End Date: 12/31/2999

- ✓ Enter an end date then save the change



# Provider File Maintenance

- Step 15: Servicing Provider Information
  - ✓ Viewing a Servicing Providers taxonomy codes

Close Required Credentials Undo Update

**Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.**

**View/Update Provider Data Individual: Servicing Provider Business Process Wizard**

**Business Process Wizard - Provider Data Modification (Individual).** In order to finalize submission of your requested changes, you must complete

<input type="checkbox"/>	Step	Required	Last Modification Date	Last Review Date	Status
<input type="checkbox"/>	Step 1: Basic Information	Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 2: Locations	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 3: Specializations	Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 4: Ownership Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 5: Licenses and Certifications	Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 6: Training and Education	Optional	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 7: Identifiers	Optional	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 8: Contract Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 9: Federal Tax Details	Optional	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 10: Invoice Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 11: EDI Submission Method	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 12: EDI Billing Software Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 13: EDI Submitter Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 14: EDI Contact Information	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 15: Billing Provider Details	Optional	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 16: Payment Details	Not Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 17: View Union Information	Required	11/06/2010	11/06/2010	Complete
<input type="checkbox"/>	Step 18: Submit Modification for Review	Required	11/06/2010	11/06/2010	Complete

- ✓ Click on Step 3: Specializations to see the taxonomy

# Provider File Maintenance

## ➤ Step 16: Payment Details

- ✓ Displayed is current payment information.
- ✓ To modify click on the "00".

The screenshot shows a web-based form titled "Payment Details:". At the top, there are "Close" and "Add" buttons. Below the title, there are filter fields: "Filter By:" followed by two input boxes and a dropdown, and "And" followed by another input box and a dropdown. Below these is a section for "And Operational Status:" with a dropdown set to "Active" and a "Go" button. The main part of the form is a table with the following columns: "Location Code", "Location Name", "Payment Method", "Start Date", "End Date", "Status", and "Operational Status". Each column header has a small triangle icon indicating it can be sorted. The table contains one row with the following data: "00" (Location Code), "MARIO HEALTH CENTER" (Location Name), "Paper Check" (Payment Method), "07/01/2008" (Start Date), "12/31/2999" (End Date), "APPROVED" (Status), and "Active" (Operational Status). At the bottom of the form, there are navigation controls: "<<" and ">>" buttons, "Viewing Page 1", a "Next >>" button, a text box containing "1", a "Go" button, a "Page Count" label, and a "SaveToXLS" button. A red arrow points to the "00" in the Location Code field.

Location Code	Location Name	Payment Method	Start Date	End Date	Status	Operational Status
00	MARIO HEALTH CENTER	Paper Check	07/01/2008	12/31/2999	APPROVED	Active

# Provider File Maintenance

## ➤ Step 16: Payment Details

- ✓ Switching to Electronic Funds Transfer (preferred)

**Payment Details:**

**Identify Payment Details**

Location: 00-MARIO HEALTH CENTER      State Wide Vendor Number:

Payment Method: ☒ Electronic Funds Transfer(Direct Deposit) ☐ Paper Check

Start Date: 07/01/2008 \*

End Date: 12/31/2999

Status: Approved

**Electronic Funds Transfer:** ←

**Electronic Funds Transfer Details**

Bank Name: \*      Routing Transit Number: \*

Account Number: \*      Account Type: Checking \*

Payment Notification Preference: Email Notification \*      EFT Test Status: \*

OK Cancel

- ✓ Enter your banking information then click **"OK"**

# Provider File Maintenance

## ➤ Step 16: Payment Details

- ✓ Fill out the Authorization Agreement for Electronic Funds Transfer form
- ✓ Have the form signed
- ✓ Fax in to 360-725-2144; or
- ✓ Mail to address on the form
- ✓ <http://www.hca.wa.gov/medicaid/providerenroll/pages/enroll.aspx#provider>

# Provider File Maintenance

## ➤ Step 17: Submit Modification for Review

**Final Submission:**

**ProviderOne ID:** 2857403      **Enrollment Type:** Group Practice

The requested modifications submitted shall be verified and reviewed by the DSHS.  
During this time, you may not make additional changes.

By clicking on the button "Submit Provider Modification", you are agreeing that the information submitted for modification is correct (Privacy and Confidentiality).

Please use your NPI in all the documentation sent to DSHS. If you do not use an NPI please use your ProviderOne ID.

**Instructions for submitting documentation:**

1. Please click on [this link](#) to display the documentation cover sheet.
2. Print the cover sheet.
3. Write the the NPI number or ProviderOne ID number in the Provider ID field on the cover sheet.
4. Include the cover sheet, with the NPI number or ProviderOne ID number, when mailing or faxing documentation to the DSHS.

**Application Document Checklist:**

Forms/Docs □ ▼	Special Instructions ▲ ▼	Source ▲ ▼	Required ▲ ▼
Training and Education	Please provide a copy of all required Training and Documentation.		NO
Tax Documents	Please provide a copy of all required Tax Documents.	<a href="http://www.irs.gov/">http://www.irs.gov/</a>	NO
Licenses and Certifications	Please provide a copy of all required Licenses and Certifications.	<a href="http://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp">http://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp</a>	NO
EDI Required Documentation	Please provide a copy of all required Trading Partner documents.		NO
Contracts and Agreements	Please provide a copy of all required Contracts and Agreements. Include a copy of the current Core Provider		NO
Business License	Please provide a copy of all business license.	<a href="http://dor.wa.gov/content/home/brd/default.aspx">http://dor.wa.gov/content/home/brd/default.aspx</a>	NO

<< Prev   Viewing Page 1   Next >>   1   Go   Page Count   SaveToXLS

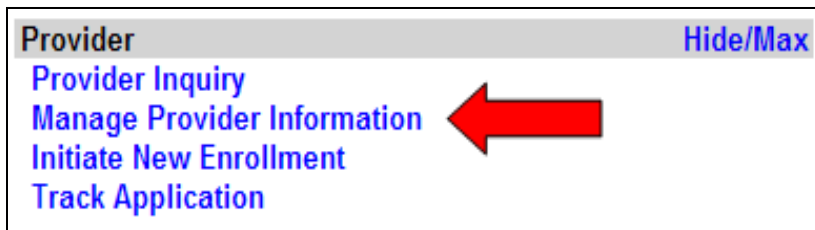
# Provider File Maintenance

- More information on provider file maintenance visit this site:
- <http://www.hca.wa.gov/medicaid/provider/pages/provideronemanuals.aspx>
- Find your manual to review.

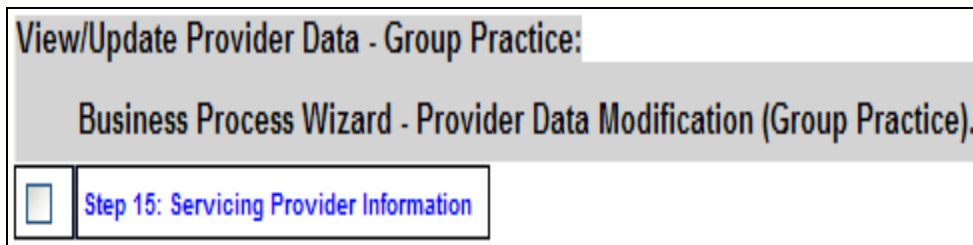
# Enroll a New Rendering Provider

# Enroll a New Rendering Provider- Existing Provider

- Log into ProviderOne using the File Maintenance or Super User profile.



Under Provider click on the hyperlink "**Manage Provider Information**".



At the Business Process Wizard click on "**Step 15: Servicing Provider Information**".



# Enroll a New Rendering Provider- Existing Provider

- When the Servicing Provider List opens, click on the **"Add"** button.

The screenshot shows a web form titled "Add Servicing Provider:". Below the title is a sub-header "Provide Servicing Provider ID Details." The form contains the following fields and controls:

- ProviderOne ID / NPI:** A text input field with an asterisk (\*) to its right. A red arrow points to this field.
- Provider Name:** A text input field.
- Start Date:** A date input field with an asterisk (\*) to its right. This field is highlighted with a red rectangular border.
- End Date:** A date input field.
- Buttons:** At the bottom right, there are three buttons: "Confirm Provider", "OK", and "Cancel". A red arrow points down to the "Confirm Provider" button.

- At the Add screen:
  - ✓ Enter the providers NPI.
  - ✓ Enter their start date at your clinic.
  - ✓ Click on the **"Confirm Provider"** button.

# Enroll a New Rendering Provider- Existing Provider

- If the provider is already entered into ProviderOne their name will be confirmed.

Add Servicing Provider:

Provide Servicing Provider ID Details.

ProviderOne ID / NPI: 1559933662 \*

Provider Name: SMITH, DAVID

Start Date: 02/01/2012 \*

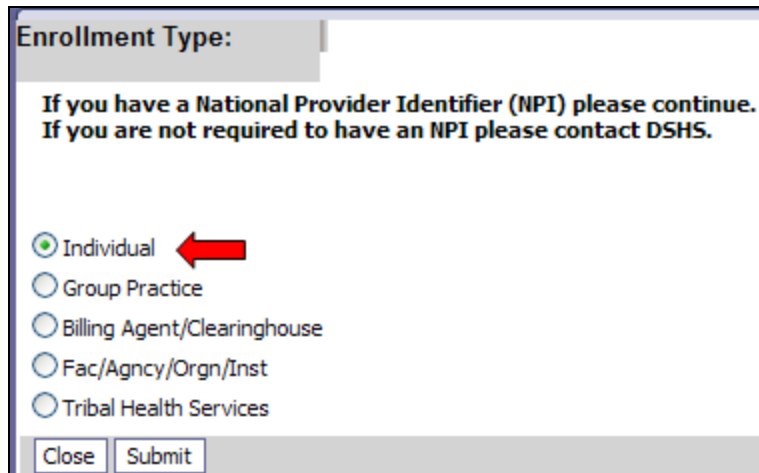
End Date:

Confirm Provider OK Cancel

- Click the **"OK"** button to add the provider to your list.
- Remember to click **"Step 18: Submit Modification for Review"**.
- The State will then review your request.


# Adding a New Rendering Provider

- There are two ways to add a new provider to your domain:
  - ✓ Follow the steps above. When you **"Confirm"** the provider and they are not in the system follow the steps below to enroll them.
  - ✓ At your Portal click on **"Initiate New Enrollment"** hyperlink.



Enrollment Type:

If you have a National Provider Identifier (NPI) please continue.  
If you are not required to have an NPI please contact DSHS.

☒ Individual 

☐ Group Practice

☐ Billing Agent/Clearinghouse

☐ Fac/Agency/Orgn/Inst

☐ Tribal Health Services

Close Submit

- ✓ Click on **"Individual"** to add the rendering/servicing provider to your domain.
- ✓ Click on the **"Submit"** button.

# Adding a New Rendering Provider

- At the Basic Information page for the rendering provider enrollment:

**Basic Information:** If you don't have NPI and if you are Atypical provider then please contact DSHS worker to enroll.

Tax Identifier Type: ☐ FEIN ☒ SSN

Organization Name:  (as shown on Income Tax Return)  
Organization Business Name:  FEIN:

First Name:  JOHN (as shown on Social Security Card) Middle Name or Middle Initial:  L  
Last Name:  SMITH (as shown on Social Security Card)  
Suffix:  MD  
SSN:  002272012 Gender:  Male  
Date of Birth:  07/15/1985 Title:   
Servicing Type:  Servicing Only

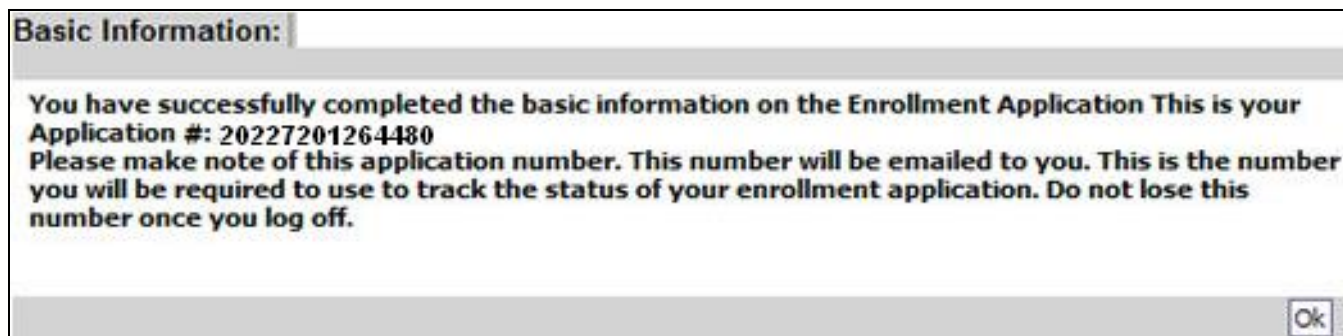
NPI:  1567890234 \* UBI:   
W-9 Entity Type:  Other \* W-9 Entity Type (If Other):  SERVICING ONLY  
Other Organizational Information:  --SELECT--  
Enrollment Effective Date:  02/01/2012  
Receive Invoice for Medical Services?:  No \*

Finish Cancel

- ✓ **Most important check the SSN radio button!**
- ✓ When filling in the rest of the data fields be sure to select **"Servicing Only"** as the Servicing Type.

# Adding a New Rendering Provider

- Once the Basic Information page is filled in click the **"Finish"** button.
- The basic information on the enrollment application is submitted into ProviderOne which generates the Application number.



- Be sure to record this application number for use in tracking the status of the enrollment application. Then click **"OK"**

# Adding a New Rendering Provider

- The Business Process Wizard - Step 1 is complete.

Close Required Credentials Undo Update

**Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.**

View/Update Provider Data - Individual:

Business Process Wizard - Provider Data Modification (Individual). In order to finalize submission of your requested - St

<input type="checkbox"/>	Step	Required	Last Modification Date	Last Review Date	Status
<input type="checkbox"/>	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
<input type="checkbox"/>	Step 2: Locations	Not Required			Incomplete
<input type="checkbox"/>	Step 3: Specializations	Required			Incomplete
<input type="checkbox"/>	Step 4: Ownership Details	Not Required			Incomplete
<input type="checkbox"/>	Step 5: Licenses and Certifications	Required			Incomplete
<input type="checkbox"/>	Step 6: Training and Education	Optional			Incomplete
<input type="checkbox"/>	Step 7: Identifiers	Optional			Incomplete
<input type="checkbox"/>	Step 8: Contract Details	Not Required			Incomplete
<input type="checkbox"/>	Step 9: Federal Tax Details	Optional			Incomplete
<input type="checkbox"/>	Step 10: Invoice Details	Optional			Incomplete
<input type="checkbox"/>	Step 11: EDI Submission Method	Optional			Incomplete
<input type="checkbox"/>	Step 12: EDI Billing Software Details	Optional			Incomplete
<input type="checkbox"/>	Step 13: EDI Submitter Details	Optional			Incomplete
<input type="checkbox"/>	Step 14: EDI Contact Information	Optional			Incomplete
<input type="checkbox"/>	Step 15: Billing Provider Details	Optional			Incomplete
<input type="checkbox"/>	Step 16: Payment Details	Not Required			Incomplete
<input type="checkbox"/>	Step 17: View Union Information	Optional			Incomplete
<input type="checkbox"/>	Step 18: Submit Modification for Review	Required			Incomplete

✓ Not all remaining steps are required.






# Adding a New Rendering Provider

➤ The steps with the arrows should be filled out.

**Important - Step 11: EDI Submission Method is REQUIRED if FTP/Web Batch Submitter or Retrieving 835s.**

**View/Update Provider Data - Individual:**

**Business Process Wizard - Provider Data Modification (Individual).** In order to finalize submission of your requested - Su

<input type="checkbox"/>	Step	Required	Last Modification Date	Last Review Date	Status
<input type="checkbox"/>	Step 1: Basic Information	Required	03/01/2012	03/01/2012	Complete
<input type="checkbox"/>	Step 2: Locations	Not Required			Incomplete
<input type="checkbox"/>	Step 3: Specializations 	Required			Incomplete
<input type="checkbox"/>	Step 4: Ownership Details	Not Required			Incomplete
<input type="checkbox"/>	Step 5: Licenses and Certifications 	Required			Incomplete
<input type="checkbox"/>	Step 6: Training and Education	Optional			Incomplete
<input type="checkbox"/>	Step 7: Identifiers 	Optional			Incomplete
<input type="checkbox"/>	Step 8: Contract Details	Not Required			Incomplete
<input type="checkbox"/>	Step 9: Federal Tax Details	Optional			Incomplete
<input type="checkbox"/>	Step 10: Invoice Details	Optional			Incomplete
<input type="checkbox"/>	Step 11: EDI Submission Method	Optional			Incomplete
<input type="checkbox"/>	Step 12: EDI Billing Software Details	Optional			Incomplete
<input type="checkbox"/>	Step 13: EDI Submitter Details	Optional			Incomplete
<input type="checkbox"/>	Step 14: EDI Contact Information	Optional			Incomplete
<input type="checkbox"/>	Step 15: Billing Provider Details 	Optional			Incomplete
<input type="checkbox"/>	Step 16: Payment Details	Not Required			Incomplete
<input type="checkbox"/>	Step 17: View Union Information	Optional			Incomplete
<input type="checkbox"/>	Step 18: Submit Modification for Review 	Required			Incomplete

# Adding a New Rendering Provider

- Step 3: Specializations
  - ✓ Add Taxonomy here.
- Step 5: Licenses and Certifications
  - ✓ Enter license/certification issued by the Department of Health.
- Step 7: Identifiers
  - ✓ If you have a Drug Enforcement Agency (DEA) number enter it here



# Adding a New Rendering Provider (Cont.)

- Step 15: Billing Provider Details
  - ✓ Add the NPI and Name of clinic that will bill for this rendering provider's services.
- Step 18: Submit Modification for Review
  - ✓ Open this and click the Submit Button to send to the State for approval.
- Send in all required supporting documentation (CPA, Certifications, etc)

# Online Services

# Online Services

## ➤ Provider's One-Stop Shopping Website

✓ <http://www.hca.wa.gov/medicaid/Provider/Pages/index.aspx>

Washington State Health Care Authority Medicaid

Health Benefits ▾ Agency Programs ▾ Health Care Reform ▾ Employment ▾ About the HCA ▾

Search this site... 🔍

**MEDICAID PROVIDERS HOME**

Print Email Bookmark & Share

**Providers Home | Training | Fact Sheets | Links | Claims and Billing | New Provider | Webinars | ProviderOne Manuals**

**Note: Browsers may need Windows update**

ProviderOne is currently not compatible with Internet Explorer (IE) 10. Microsoft is pushing out an automatic Windows 7 update. With this update, IE10 is becoming available to more users. If your office happens to upgrade to IE10, there are some simple steps you will have to take to access ProviderOne. These steps will also be available from the ProviderOne Login page in approximately 7-10 business days.

1. Go to Tools in the Internet Explorer menu bar
2. Select/click on Compatibility View option

Questions? Visit the HCA website to contact us. Your message will be delivered to the appropriate staff.

**CMMI State Innovation Models Grant**

Washington State CMMI State Innovations Grant Application Project Summary (Released 9/7/12)

**Webinar Presentations**

- State Innovation Models (SIM) Grant Webinar (8/29/12)
- CMMI Innovation Grant Update Webinar (9/7/12)
- Stakeholder Letter of Support Template

**News and Updates**

- New enrolled provider requirements effective July 1, 2012
- FAQ about the new Medicaid requirements for Ordering, Prescribing, and Referring Providers
- Emergency Room changes planned for July 1, 2012.
- Medicare and Medicaid: Dual eligibles project posted.

**You may also want to visit:**

- Budget Cuts how they affect the Medicaid Program
- ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage
- Join the Medicaid email list for providers to get the latest information specific to your business
- ProviderOne Weekly Claims Report Providers can check their claim statistics by tax ID then NPI
- Scope of Care client coverage eligibility for services
- Coordination of Benefits
- A Provider link to ProviderOne Note: this link is for external providers and will not work for internal staff
- Contact the Customer Service Center

# Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Training tab

The screenshot displays the Washington State Health Care Authority Medicaid website. The header includes the agency logo and a navigation bar with links: Health Benefits, Agency Programs, Health Care Reform, Employment, and About the HCA. A search bar is located below the header. On the left, a sidebar menu lists various services under categories like Medicaid, Client Services, Provider Information, and Administration. The main content area is titled 'TRAINING' and features a red arrow pointing to the 'Webinars' link in the navigation bar. Below this, the text describes the Medicaid Program's learning opportunities and lists resources such as 'Add a DEA number to a provider file', 'New Tribal Billing Method Training', and 'Medicaid Provider Relations is offering Medicaid 101 training workshops'. A yellow box on the right titled 'You may also want to visit:' contains additional links. The footer of the page mentions a pilot program to reduce wait times for the Customer Service phone line.

Washington State Health Care Authority Medicaid

Health Benefits | Agency Programs | Health Care Reform | Employment | About the HCA

Search this site...

**Medicaid**

- Home
- Contact Medicaid
- Programs and Services Directory

**Client Services**

- Health Care Assistance
- Healthy Options/Managed Care

**Provider Information**

- Provider Services
- Durable Medical Equipment
- Hospital Payments
- Provider Guides and Notices

**Administration**

- Forms
- Provider Termination and Exclusion List
- Publications
- Reports
- State Plan for Medicaid

**TRAINING**

Print | Email | Bookmark & Share

**Providers Home | Training | Fact Sheets | Links | Claims and Billing | New Provider | Webinars | ProviderOne Manuals**

The Medicaid Program offers a variety of learning opportunities for providers. These include live webinars, E-learning lessons, tutorials, and manuals.

**Add a DEA number to a provider file.** ProviderOne has been updated to accept a provider's DEA number on their provider file in the system and the process is demonstrated in the following presentation.

- Add a DEA Number

**New Tribal Billing Method Training.** Provider Relations in cooperation with the Tribal program has produced a presentation explaining the new coding billing method for tribal claims.

- New Tribal Billing presentation

**Medicaid Provider Relations is offering Medicaid 101 training workshops.** The 2013 workshop schedule has not been established yet.

**Good News,** these Medicaid workshops have been approved by the AAPC as meeting the requirements for 5.0 CEU's continuing education hours. All certified coders that attend will be given a certificate of workshop completion.

The following workshop has been completed:

- Medicaid 101 Workshop - Presentation slide show
- Dental Medicaid 101 Workshop - Presentation slide show

Additional Training resources include:

- Operational Webinars
- ProviderOne System Tutorials
- ProviderOne System E-Learning sessions

Pilot program to reduce wait times for the Customer Service phone line. Take the P.E.R.K. training now.

**You may also want to visit:**

- Budget Cuts how they affect the Medicaid Program
- ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage
- Join the Medicaid email list for providers to get the latest information specific to your business
- ProviderOne Weekly Claims Report Providers can check their claim statistics by tax ID then NPI
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- Coordination of Benefits
- A Provider link to ProviderOne Note: this link is for external providers and will not work for internal staff
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# Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Webinars with each hyperlink

The screenshot displays the Washington State Health Care Authority Medicaid website. The top navigation bar includes links for Health Benefits, Agency Programs, Health Care Reform, Employment, and About the HCA. A search bar is located on the left. The main content area is titled 'WEBINARS' and features a sidebar with various menu items. A red arrow points from the 'Programs and Services Directory' menu item to the 'Webinars Available' section. Another red arrow points from the 'Provider Services' menu item to the 'Applied Behavioral Analysis Center for Excellence' section. The 'Webinars Available' section lists several topics, including Applied Behavioral Analysis Center for Excellence, Billing a Client, Enrolling Pharmacists into ProviderOne, and more. The 'Applied Behavioral Analysis Center for Excellence' section provides details about accessing ABA services and a recorded webinar. The 'Billing a Client' section explains when a provider can bill a Medicaid client and provides links to the presentation and questions & answers. The 'Enrolling Pharmacists into ProviderOne' section mentions a webinar and presentation slide show. A 'News' section on the right mentions updates to webinar presentation slides. A 'You may also want to visit:' section lists additional resources like Budget Cuts, ProviderOne Billing and Resource Guide, and a Medicaid email list.

Washington State Health Care Authority  
Medicaid

Health Benefits | Agency Programs | Health Care Reform | Employment | About the HCA

Search this site...

**WEBINARS**  
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**Medicaid**  
Home  
Contact Medicaid  
Programs and Services Directory

**Client Services**  
Health Care Assistance  
Healthy Options/Managed Care

**Provider Information**  
Provider Services  
Durable Medical Equipment  
Hospital Payments  
Provider Guides and Notices

**Administration**  
Forms  
Provider Termination and Exclusion List  
Publications  
Reports  
State Plan for Medicaid

**Providers Home | Training | Fact Sheets | Links | Claims and Billing | New Provider | Webinars | ProviderOne Manuals**

**Webinars Available**

- Applied Behavioral Analysis Center for Excellence
- Billing a Client
- Enrolling Pharmacists into ProviderOne
- How to Navigate the Interactive Voice Response (IVR) System
- Interpreting Client Eligibility Information Returned by ProviderOne
- Managed Care Providers
- Nursing Home Providers
- Prior Authorization
- Submit Fee For Service Claims (Professional, Dental, Institutional)
- Tribal Billing

**Applied Behavioral Analysis Center for Excellence**

- Accessing ABA Services for Clinicians
- Recorded Webinar for August 31, 2012

**Billing a Client**

This webinar covers when a provider may be able to bill a Medicaid client for healthcare services in limited circumstances. It covers the provider's responsibilities and when a provider may need the only acceptable waiver form 13-879 (Agreement to Pay for Healthcare Services) signed by the provider and client before the service date.

- Presentation
- Review the Questions & Answers from the Webinar

**Enrolling Pharmacists into ProviderOne**

To assist in enrollment of all Pharmacists, Provider Relations in cooperation with Provider Enrollment and the Pharmacy program have produced a webinar and presentation slide show with step by step instructions for enrolling pharmacists into ProviderOne.

**News**  
All Webinar presentation slides have been updated to reflect the ProviderOne system changes due to the implementation of the HIPAA 5010 system format. Payment of Mental Health Medications

- Recorded Webinar

**You may also want to visit:**

- Budget Cuts how they affect the Medicaid Program
- ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage
- Join the Medicaid email list for providers to get the latest information specific to your business
- ProviderOne Weekly Claims Report Providers can check their claim statistics by tax ID then NPI
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- Coordination of Benefits
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# Online Services

- Provider's One-Stop Shopping Website (cont'd)
  - ✓ Links Tab

Washington State Health Care Authority Medicaid

Search this site...

Health Benefits | Agency Programs | Health Care Reform | Employment | About the HCA

### MEDICAID PROVIDER LINKS

Print | Email | Bookmark & Share

**Providers Home | Training | Fact Sheets | Links | Claims and Billing | New Provider | Webinars | ProviderOne Manuals**

Here are some information links that may be useful to a Medicaid Provider:

- Allen Emergency Medical Program (AEM)
- Authorization Services
- Autism
- Billing Instructions
- Coordination of Benefits
- Dental Services
- Department of Social and Health Services (DSHS)
- DSHS Division of Behavioral Health & Recovery (DBHR)
- Document Cover Sheets
- Drug Use Assistance
- Durable Medical Equipment
- Electronic Health Record Incentive Program
- Emergency Rooms
- Federal EOB and Taxonomy Code list
- Federally Qualified Health Centers and Rural Health Clinics
- Health Care Authority
- Health Care Programs & Services
- Healthy Options (Managed Care)
- HIPAA Home Page
- Hospital Payments
- Interpreter Services
- Kidney Disease Program
- Medicaid Rule Making Actions
- Medicaid State Plan
- Mental Health Services
- NPPES
- Numbered Memos
- Optical Providers for Adult Medicaid Clients
- Pharmacy Information Site
- Professional Services Rates
- Provider Enrollment
- ProviderOne Billing and Resource Guide
- ProviderOne Information
- ProviderOne Log-In
- ProviderOne Security
- ProviderOne System Manuals
- Patient Review & Coordination Program
- Regional Support Networks (RSN)
- Substance Abuse Help
- Swipe Card Readers
- Tribal Health
- Washington Administrative Code (WAC)

**You may also want to visit:**

- Budget Cuts how they affect the Medicaid Program
- ProviderOne Billing and Resource Guide an overview of Medicaid, billing, and system usage
- Join the Medicaid email list for providers to get the latest information specific to your business
- ProviderOne Weekly Claims Report Providers can check their claim statistics by tax ID then NPI
- Scope of Care client coverage eligibility for services
- Coordination of Benefits
- A Provider link to ProviderOne Note: this link is for external providers and will not work for internal staff
- Contact the Customer Service Center

Easy to find direct links to Medicaid Programs

# Online Services

## ➤ ProviderOne Billing and Resource

# **ProviderOne Billing and Resource Guide**

[http://www.hca.wa.gov/medicaid/billing/pages/providerone\\_billing\\_and\\_resource\\_guide.aspx](http://www.hca.wa.gov/medicaid/billing/pages/providerone_billing_and_resource_guide.aspx)



This Guide:

- Provides general information that applies to most Medicaid providers.
- Takes providers through the process for billing the Medicaid Program of the Health Care Authority for covered services delivered to eligible clients.

# Contact Us

## ContactUs!

Select one to request more information about Washington Apple Health (Medicaid):

If you are looking for more information about eligibility, health plans, services cards or finding a provider click here:

Client

If you are a provider with questions about enrollment, billing policy, a claim denial or service limitations click here:

Provider

<https://fortress.wa.gov/dshs/p1contactus/>



# Contact Us

**ContactUs!**  
Information Request Form for Providers

Your Email Address:	<input type="text"/>
7 digit Provider ID: (Enter NPIs in Comments)	<input type="text"/>
FirstName:	<input type="text"/>
Business or Last Name:	<input type="text"/>
Select Topic:	<--Select-->
Other Comments:	<input type="text"/>

- Using the drop down Select Topic, gives the following topics to choose from:

<--Select-->

- <--Select-->
- Authorization
- Billing/Policy
- Claim Denial
- Client Eligibility Clarification
- Create Template/Batch
- Ordering-Referring-Prescribing
- Overpayment Dispute
- Provider Enrollment
- Service Limits
- Other

- 48 hour turnaround for **Service Limit** checks
- ✓ Be sure to include the Date of Service (DOS)
  - ✓ Procedure Code and the date range for search
  - ✓ ProviderOne Domain number

# Contact Us

## ContactUs!

### Information Request Form for Providers

Your Email Address:

providerrelations@hca.wa.gov

7 digit Provider ID:

1223333

(Enter NPIs in Comments)

FirstName:

Marci

Business or Last Name:

PRU Dental

Select Topic:

Service Limits

Client ID

002451234WA

AND: Date of Service (mm/dd/yyyy)

6/5/2014



Procedure Code:

D1110

Type of service:

Prophy

Other Comments:

NPI 1234567890 - Please check D1110 for last 6 months. Thank you!

Submit Request

Cancel

*\*All responses to this box will be via email*



# Online Resources

## ➤ Helpful Links Related To Client Eligibility

For the following fact sheets, use the hyperlink listed below:

- Client Services Card Fact Sheet
- Client Eligibility Verification Fact Sheet
- Interactive Voice Response Fact Sheet
- Magnetic Card Reader Fact Sheet
- <http://www.hca.wa.gov/medicaid/provider/pages/factsheets.aspx>

E-Learning webinar on how to check eligibility in ProviderOne:

<http://www.hca.wa.gov/medicaid/provider/Pages/webinar.aspx>

- Instructions available in Program Update memo dated [May 31, 2012](#)

Self-paced online tutorial on how to check Medicaid eligibility:

<http://www.hca.wa.gov/medicaid/ProviderOne/pages/phase1/tutorials.aspx>

ProviderOne Billing and Resource Guide:

[http://www.hca.wa.gov/medicaid/provider/Pages/providerone\\_billing\\_and\\_resource\\_guide.aspx](http://www.hca.wa.gov/medicaid/provider/Pages/providerone_billing_and_resource_guide.aspx)

# Online Resources

Provider Training website for links to recorded Webinars, E-Learning, and Manuals

- <http://www.hca.wa.gov/medicaid/provider/pages/training.aspx>

Provider Enrollment website

- <http://www.hca.wa.gov/medicaid/provider/pages/newprovider.aspx>

Billing Questions

- [providerrelations@hca.wa.gov](mailto:providerrelations@hca.wa.gov)

